Loss of Speech

Physician's Statement (Specialist only)

PLEASE PRINT

Name of patient: _____ _____
Surname First Name Date of Birth (mm/dd/yy)

Address: _____
Number & Street City Province Postal Code

Telephone ( ) _____

1. a) On what date did the patient first consult you for loss of speech? Date (month, day, year) _____

   b) How long has this person been your patient? _____

2. On what date did your patient first have symptoms or become aware of the loss of speech? Please provide details.

   (mm/dd/yy) _____

3. a) Please provide details, including dates, of the injury or disease causing loss of speech (mm/dd/yy).

   _____

   b) Is the loss of speech permanent and irreversible? _____

   c) Please describe the degree of loss of speech. _____

   _____

4. Were there any associated neurological or psychological complications including hysterical aphonia?

   _____

5. Please indicate duration and frequency of any speech therapy sessions.

   _____

   _____

6. Has there been any improvement in the patient's speech since the onset of the condition?

   _____

   _____

7. What investigators or tests have been performed to verify the diagnosis of permanent loss of speech?

   _____

   _____

THE WAWANESA LIFE INSURANCE COMPANY
236 Carlton St, Winnipeg, Manitoba R3C 1P5
Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

8. Please give the names and addresses of other physicians or speech therapists consulted or hospitals attended by your patient for this condition:

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date from** (month, day, year)	**Date to** **(month, day, year)**

9. Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital records

Name (Please print) | Degree

Street Address | City | Province | Postal Code

Area Code & Telephone Number | FAX number

Date (mm/dd/yy) | Signature MD

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy officer.