PHYSICIAN'S STATEMENT

Erectile Dysfunction Drugs

Please Print

Group # _____ **Certificate #** _____

Insured _____ **Patient** _____

Physician *Name* _____ *Telephone* _____

Address _____

City, Prov., P.C. _____

1. Diagnosis of Present Condition

   _____

2. Commencement of Condition *(yy/mm/dd)* _____

3. Does the patient have any of the following conditions:

   - Diabetes
   - Hypertension
   - Peripheral Vascular Disease
   - Neurological or Endocrine Disease
   - Medication Induced Erectile Dysfunction

4. Any other pertinent medical information which would help to assess the claim

   _____

   _____

   _____

Authorization: I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I certify that the charges listed above and for which the bills are attached, were incurred by myself or one of my eligible Dependents. The charges were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true. I hereby authorize the release to RWAM Insurance Administrators Inc., of any information in respect to this claim requested by RWAM. This authorization will remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

(The Patient is responsible for securing this form and for charges made for its completion.)

Date _____ Patient's Signature _____

Date _____ Physician's Signature _____

RWAM INSURANCE ADMINISTRATORS INC.

49 Industrial Drive, Elmira, Ontario N3B 3B1 Tel. 519-669-1632, 1-877-888-RWAM (7926) Fax 519-669-1923 www.rwam.com