



Please submit this form and all related correspondent to:

**WEA Administrators**

2525 Embassy Drive, Suite 15  
Cooper City, FL 33026 - USA

Phone 1 (954) 889-2100  
Fax 1 (954) 241-2002  
Email info@wwexpa.com  
URL www.weadirect.com

**IMPORTANT: PLEASE READ INSTRUCTIONS CAREFULLY**

The requested information is required to consider the following patient for medical coverage.

- Please complete all areas
- Use additional paper, if necessary

Name of Patient

Date of Birth (MM/DD/YY)  Height  Weight

1. Diagnosis:

2. Date(s) Diagnosed: (MM/DD/YY)

3. Etiology

4. Present Medications  Dose:  mg

Frequency and dates of usage:  MM/DD/YY  MM/DD/YY

5. Laboratory Findings (including X-Ray, ECG, BMR, Blood Chemistry Profile and Path Reports, etc.)

6. Progress (Surgeries, treatments, etc.):

7. Prognosis:

8. Date of Recovery: (MM/DD/YY)

9. Additional information which might affect patient's health:

Physician's Name

Date (MM/DD/YY)

Physician's Signature