2288-555 Hastings Street West
Vancouver BC V6B 4N6

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYEE STATEMENT

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee		Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address - No., street, apt.	City	Province	Postal code
Policy no.	Division no.	Certificate or identification no.	Social insurance no.

Home telephone no.: (   )   -

B - GENERAL INFORMATION

1. Training:

Level of education:

Work experience:

Spoken language: ☐ English ☐ French Written language: ☐ English ☐ French

2. Is disability due to an accident? ☐ Yes ☐ No

If "Yes", date of accident: YYYY MM DD

Time ☐ AM ☐ PM

Type of accident ☐ Work-related ☐ Motor vehicle ☐ Other

Indicate details (where, how and witnesses):

3. Did you receive prior treatment for the illness or injury causing the disability? ☐ Yes ☐ No

If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists:

4. Name, address and telephone number of physicians and specialists who have treated you during the disability:

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

B - GENERAL INFORMATION (CONT'D)

5. If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Date benefits commence	Benefit period	Benefit amount	Weekly/Monthly
			YYYY MM DD	FROM: TO:		☐ W ☐ M
			YYYY MM DD	FROM: TO:		☐ W ☐ M

COMMENTS: ___

I hereby certify that the above answers are full and true.

SIGNATURE OF EMPLOYEE: **DATE:**

C - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

D - AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

I authorize Desjardins Financial Security Life Assurance Company to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

SIGNATURE OF EMPLOYEE: **DATE:**

VERY IMPORTANT

PLEASE HAVE THE INITIAL ATTENDING PHYSICIAN'S STATEMENT COMPLETED AND FORWARD COMPLETED FORMS TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY, DISABILITY CLAIMS.

Desjardins Insurance
LIFE • HEALTH • RETIREMENT

2288-555 Hastings Street West
Vancouver BC V6B 4N6
Fax: 604-688-3917

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM

EMPLOYER STATEMENT

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee	Certificate or identification no.	Social insurance no.

Address of employee - No., street, apt.	City	Province	Postal code

Telephone no.: ( ) -

Name of policyholder or employer	Policy no.	Division no.

Address of policyholder or employer - No., street, suite	City	Province	Postal code

Telephone no.: ( ) - Fax no.: ( ) -

COMPLETE IF SELF-ADMINISTERED: **Effective date of coverage:** YYYY MM DD **Class no.:**

B - GENERAL INFORMATION

1. Current salary
☐ Weekly ☐ Monthly
☐ Every two weeks $

2. Salary effective date YYYY MM DD

3. Job status
☐ Full time
☐ Part time

4. Indicate days in normal work week
☐ SUN ☐ MON ☐ TUE ☐ WED
☐ THU ☐ FRI ☐ SAT
Hours worked per week

4.A
☐ Rotating schedule
☐ Variable schedule

5. Premium paid by
☐ Employer
☐ Employee
☐ Both

6. Deductions
☐ Weekly
☐ Every two weeks
☐ Monthly

	Exemption Code	Tax Withheld at Source	CPP/QPP Contribution	EI Contribution (HRSDC)	Parental insur. (QPIP) Qc only
Federal					
Provincial					

7. Date of employment YYYY MM DD

8. Occupation

9. Date last worked YYYY MM DD
No. of hours worked

10. Did or will the employee receive any income during the disability period? ☐ Yes ☐ No **If "Yes"**, indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)

Type: **Amount:** **Period:**

11. If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CSST (Québec only)? ☐ Yes ☐ No

12. Has a claim been filed with a government agency? ☐ Yes ☐ No **If "Yes"**, indicate below:
☐ CSST/WCB/WSIB/WHSCC ☐ CPP/QPP ☐ SAAQ (Québec only) ☐ No Fault (outside Québec only)
☐ Other, specify: ____________________

Date Filed: YYYY MM DD **Decision Rendered:** **Amount:**

13. Has the employee returned to work? ☐ Yes ☐ No **If "Yes"**, on what date? YYYY MM DD

14. Is this person still in your employ?
☐ Yes ☐ No **If "No"**, specify termination date: YYYY MM DD Reason:

15. Was this person given a record of employment? ☐ Yes ☐ No

16. Is there any reason why this claim should not be paid? ☐ Yes ☐ No Comments, if any:

____

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

C - PHYSICAL WORK ENVIRONMENT

Please attach a brief job description if available.

1. What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties ______ | ____ % **Duties** ______ | ____ %

Duties ______ | ____ % **Duties** ______ | ____ %

For questions 2 and 3, FREQUENCY is defined as follows:

OCCASIONALLY: 0-15 % of the time **FREQUENTLY: 16-50 % of the time** **ALWAYS: 51 % + of the time**

2. Work environment - Does the employee's job require work in any of the following conditions?

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
☐ Outside	☐	☐	☐	☐ In a damp or humid environment	☐	☐	☐	☐ Above or below ground level	☐	☐	☐
☐ In extremes of cold or heat	☐	☐	☐	☐ Toxic fume	☐	☐	☐	☐ Handling chemicals	☐	☐	☐

Does the job involve other hazards? ☐ Yes ☐ No **If "Yes"**, please list:

3. Check the items below that relate to the employee's job, and complete the information requested.

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
☐ Standing	☐	☐	☐	☐ Bending over	☐	☐	☐	☐ Extending/reaching above head	☐	☐	☐
☐ Walking	☐	☐	☐	☐ Kneeling	☐	☐	☐	☐ Climbing	☐	☐	☐
☐ Sitting	☐	☐	☐	☐ Crouching	☐	☐	☐	☐ Stairs (No. of steps ______)	☐	☐	☐
☐ Keeping one's balance	☐	☐	☐	☐ Crawling	☐	☐	☐	☐ Ladders (Height ______)	☐	☐	☐

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY: O	F	A	WEIGHT:
☐ Pushing ______	☐	☐	☐	☐ Lb ☐ Kg
☐ Pulling ______	☐	☐	☐	☐ Lb ☐ Kg
☐ Lifting/carrying ______	☐	☐	☐	☐ Lb ☐ Kg

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment ______ | Times per day ______

Type of equipment ______ | Times per day ______

4. Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? ☐ Yes ☐ No

If "Yes", please specify: ______

5. Does the employee's job require dexterity? ☐ Yes ☐ No

If "Yes", please specify: ______

6. Are there any other potential work-related factors which may influence this employee's return to work? ☐ Yes ☐ No

If "Yes", please specify: ______

SIGNATURE OF THE AUTHORIZED PERSON

Last name and first name of the authorized person (IN BLOCK LETTERS) ______ Position ______

Signature ______ **Date** ______

Desjardins
Insurance
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IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	**Form no. 12018E19**
- Musculo-skeletal	**Form no. 12019E19**
- Psychiatric/psychological	**Form no. 12020E19**
- Cardiac	**Form no. 12021E19**
- Cancer	**Form no. 12022E19**

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Return the completed form to Desjardins Financial Security Life Assurance Company at the address below no later than six weeks prior to the start of your long-term disability period.

Desjardins Financial Security Life Assurance Company
PO Box 12081
Vancouver BC V6B 4N5

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Desjardins Insurance
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2288-555 Hastings Street West
PO Box 12081
Vancouver BC V6B 4N5

GROUP INSURANCE - DISABILITY CLAIMS

Initial Attending Physician's Statement
General form

- A PLEASE PRINT.
- B PART 1 to be completed by patient.
- C PART 2 to be completed by physician.
- D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

First and last names (PLEASE PRINT)

Date of birth YYYY MM DD

Address - No., street, apt. | City | Province | Postal code

Telephone no. ( ) - | Contract no. | Certificate no.

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications). If psychiatric, give DSM-IV code

1.1 Primary: ____

1.2 Secondary: ____

1.3 Subjective symptoms (including severity, frequency, duration): ____

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings)

1.5 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements

2. History

2.1 Date symptoms first appeared or accident happened: Y Y Y Y M M D D

2.2 Date patient's condition first prevented them from working: Y Y Y Y M M D D

2.3 Has this patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment: ____

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☐ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

2.6 If patient is pregnant, give E.D.C.: Y Y Y Y M M D D

2.7 Names and specialties of other treating physicians: ____

2.8 Current height: Current weight: Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: Y Y Y Y M M D D

3.2 Date of latest visit: Y Y Y Y M M D D

3.3 Frequency of visits: ☐ Weekly ☐ Monthly

☐ Other (specify): ____

3.4 Date of in-patient admission: Y Y Y Y M M D D

3.5 Date of discharge: Y Y Y Y M M D D

3.6 Date of out-patient treatment: Y Y Y Y M M D D

3.7 Name of hospital: ____

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): ____

4.2 Surgeries (including dates): ____

4.3 Other (including frequency): ____

4.4 Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate): ____

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

5. Progress

5.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed
5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			< 1	< 1-2	< 2-4	4-6	6-8	< 1	< 1-2	< 2-4	4-6	6-8
6.1 Stand	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2 Walk	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3 Walk on uneven surfaces	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4 Sit	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5 Drive	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6 This patient can lift/carry a maximum of:		kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
6.7 ☐ No restriction	☐ Repetitively: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
Drive: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulder):

7. Psychiatric illness (if applicable)

7.1 History: ______
7.2 Precipitating chronological events: ______
7.3 Work issue related to this illness: ______
7.4 Pre-morbid personality: ______
7.5 Changes in ADL habits: ______
7.6 Familial risk factors: ______
7.7 Progress with treatment plan: ______
7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☐ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility: ______
7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when: Y Y Y Y M M D D

8. Return to work plans

8.1 Prognosis for improvement or recovery: ______
8.2 Expected date patient will return to their own occupation: Y Y Y Y M M D D
8.3 If unknown, please indicate the next follow up date: Y Y Y Y M M D D
8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: ______
8.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No
8.6 Please elaborate on time frames and patient's response: ______

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No
If yes, please specify: ______
9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify: ______

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements? ______

11. Identification of physician

11.1 First and last names (PLEASE PRINT)

11.2 Specialty | License no.

11.3 Address - No., street, office | City | Province | Postal code

11.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: **Date:**

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2288-555 Hastings Street West
PO Box 12081
Vancouver BC V6B 4N5

GROUP INSURANCE - DISABILITY CLAIMS

Initial Attending Physician's Statement
Musculo-Skeletal form

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

First and last names (PLEASE PRINT)

Date of birth YYYY MM DD

Address - No., street, apt. | City | Province | Postal code

Telephone no. ( ) - | Contract no. | Certificate no.

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis

1.1 Primary: ______

1.2 Secondary: ______

1.3 Date symptoms first appeared: Y Y Y Y M M D D

1.4 Date patient's condition first prevented them from working: Y Y Y Y M M D D

1.5 Date of first visit for treatment or consultation: Y Y Y Y M M D D

1.6 Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe: ______

1.7 Is condition a result of an injury due to an accident? ☐ Yes ☐ No If yes, please describe: ______

1.8 Current height: ______ Current weight: ______ Weight loss/gain to date: ______

1.9 Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
If yes, have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No

1.10 Date of latest visit: Y Y Y Y M M D D

1.11 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): ______

1.12 Date of hospital inpatient admission: Y Y Y Y M M D D

1.13 Date of discharge: Y Y Y Y M M D D

1.14 Date of hospital outpatient admission: Y Y Y Y M M D D

1.15 Name of hospital: ______

1.16 Other treating physicians: ______

1.17 Pending referrals to specialists: ______

2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		

3. Symptoms and signs

Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle spasm		☐	☐	☐	☐
Muscle atrophy		☐	☐	☐	☐
Loss of tendon reflexes		☐	☐	☐	☐
Sensory change		☐	☐	☐	☐
Motor deficit		☐	☐	☐	☐
Straight leg raising limitation		☐	☐	☐	☐
Range of motion limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If arthritic condition: ☐ In remission ☐ Continuously active ☐ Stable ☐ Seasonally active ☐ Intermittently active ☐ Progressive

If fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): ______

4.2 Physiotherapy (type, frequency, dates): ______

4.3 Surgery date (past): Y Y Y Y M M D D Surgery date (future): Y Y Y Y M M D D

4.4 Other treatment: ______

4.5 Is patient compliant with prescribed measures? ☐ Yes ☐ No If no, please explain: ______

5. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			< 1	< 1-2	< 2-4	4-6	6-8	< 1	< 1-2	< 2-4	4-6	6-8
5.1 Stand	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.2 Walk	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.3 Walk on uneven surfaces	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.4 Sit	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.5 Drive	☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.6 This patient can lift/carry a maximum of:		kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
5.7 ☐ No restriction	☐ Repetitively: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):

Drive: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulders):

6. Prognosis and return to work plans

6.1 Prognosis for recovery: ______

6.2 Expected date patient will return to their own occupation: Y Y Y Y M M D D

6.3 If unknown, please indicate the next follow up date: Y Y Y Y M M D D

6.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: ______

6.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No

6.6 Please elaborate on time frames and patient's response: ______

7. Progress

7.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

7.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

8.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

8.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

8.3 ☐ Work related issues (please describe if known): ______

8.4 ☐ Substance abuse: ______

8.5 ☐ Other (please describe): ______

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: ______

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements? ______

______

______

______

11. Identification of physician

11.1 First and last names (PLEASE PRINT)

11.2 Specialty	License no.

11.3 Address - No., street, office	City	Province	Postal code

11.4 Telephone no.: ( ) -	Fax no.: ( ) -

Signature of physician: **Date:**

Desjardins Insurance
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2288-555 Hastings Street West
PO Box 12081
Vancouver BC V6B 4N5

GROUP INSURANCE - DISABILITY CLAIMS

Initial Attending Physician's Statement
Psychiatric/psychological form

Ⓐ PLEASE PRINT.
Ⓑ PART 1 to be completed by patient.
Ⓒ PART 2 to be completed by physician.
Ⓓ Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

First and last names (PLEASE PRINT) | Date of birth YYYY MM DD

Address - No., street, apt. | City | Province | Postal code

Telephone no. ( ) - | Contract no. | Certificate no.

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any psychiatric/counsellor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (please use DSM-IV criteria)

1.1 Axis I: ______
1.2 Axis II: ______
1.3 Axis III: ______
1.4 Axis IV: ______
1.5 Axis V - Current GAF score:

Supporting data
Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.

2. History

2.1 When did symptoms start and/or worsen? Y Y Y Y M M D D
2.2 Date patient's condition first prevented them from working? Y Y Y Y M M D D
2.3 Date of first visit for treatment or consultation. Y Y Y Y M M D D
2.4 Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe: ______
2.5 Were work problems a factor in the development of your patient's disorder? ☐ Yes ☐ No If yes, please describe: ______
2.6 Has a claim been filed with the Workers compensation Board? ☐ Yes ☐ No
2.7 Date of latest visit: Y Y Y Y M M D D
2.8 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: ______
2.9 Are patient's symptoms due to drug or alcohol abuse? ☐ Yes ☐ No
2.10 If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility: ______
2.11 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when: Y Y Y Y M M D D

3. Treatment for psychiatric/psychological illness

3.1 Is patient seeing or being referred to a psychiatrist? ☐ Yes ☐ No If yes, name of psychiatrist: ______
3.2 If pending, is there an appointment date? ☐ Yes ☐ No Y Y Y Y M M D D
3.3 Is patient seeing or being referred to a therapist? ☐ Yes ☐ No If yes, name of therapist: ______
3.4 Date of hospital inpatient admission: Y Y Y Y M M D D Date of discharge: Y Y Y Y M M D D
Name of hospital:

4. Precipitating and complicating factors

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

☐ Workplace issues ☐ Social/Family issues ☐ Physical/Mental condition ☐ Financial/Legal problems
☐ Coping skills ☐ Alcohol/Drug abuse ☐ Personality/Motivation ☐ Other issues

Comments: ______

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5. Current treatment

5.1 Therapy method: ______

5.2 Therapy goal: ______

5.3 Frequency and length of therapy/counselling sessions: ______

5.4 Number of therapy/counselling sessions to date: ______

5.5 Treatment compliance: ______

5.6 Treatment response to date: ______

5.7 Prognosis and time frame of illness: ______

Medications: Medication name				
Date started (YYYY/MM/DD)				
Initial dosage				
Initial response				
Date of last dosage change (YYYY/MM/DD)				
Current dosage				
Response				
Side effects				
Compliance				
Date medication discontinued (YYYY/MM/DD)				

6. Future treatment plans

What changes in your treatment plan are underway or are being considered? ______

7. Return to work plans

7.1 Prognosis for recovery: ______

7.2 Expected date patient will return to their own occupation: Y Y Y Y M M D D

7.3 If unknown, please indicate the next follow up date: Y Y Y Y M M D D

7.4 If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work.) ______

7.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No

7.6 Please elaborate on time frames and patient's response: ______

7.7 Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No If yes, please specify: ______

7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? ______

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition, treatment requirements, and motivation to return to work? ______

9. Identification of physician

9.1 First and last names (PLEASE PRINT)

9.2 Specialty | License no.

9.3 Address - No., street, office | City | Province | Postal code

9.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: **Date:**

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GROUP INSURANCE - DISABILITY CLAIMS

Initial Attending Physician's Statement
Cardiac form

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

First and last names (PLEASE PRINT)

Date of birth YYYY MM DD

Address - No., street, apt. | City | Province | Postal code

Telephone no. ( ) - | Contract no. | Certificate no.

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) If psychiatric, give DSM-IV code

1.1 Primary: ______

1.2 Secondary: ______

1.3 Date symptoms first appeared: Y Y Y Y M M D D

1.4 Date patient's condition first prevented them from working: Y Y Y Y M M D D

1.5.1 Date of first visit: Y Y Y Y M M D D

1.5.2 Date of latest visit: Y Y Y Y M M D D

1.6 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): ______

1.7.1 Date of in-patient admission: Y Y Y Y M M D D

1.7.2 Date of discharge: Y Y Y Y M M D D

1.8 Date of out-patient treatment: Y Y Y Y M M D D

1.9 Name of hospital: ______

1.10 Subjective symptoms (including severity/frequency/duration):

2. Findings

2.1 ☐ Chest pain of cardiac origin: ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia ☐ Psychophysiologic

☐ Other (please specify): ______

2.2 BP readings over the last 6 months (including dates): ______ Y Y Y Y M M D D

______ Y Y Y Y M M D D ______ Y Y Y Y M M D D

______ Y Y Y Y M M D D ______ Y Y Y Y M M D D

2.3 Current height: ______ Current weight: ______ Weight loss/gain to date: ______

2.4 Current status: ☐ Stable ☐ Improving ☐ Regressing

3. Laboratory tests (completed/scheduled) Please include copies of relevant test results

a) EKG: Y Y Y Y M M D D

b) Echocardiogram: Y Y Y Y M M D D

c) Stress thallium test: Y Y Y Y M M D D

d) Pulmonary function test: Y Y Y Y M M D D

e) Blood test: Y Y Y Y M M D D

f) X-rays: Y Y Y Y M M D D

g) Angiogram: Y Y Y Y M M D D

4. Treatment

4.1 Medications (dose, frequency, date prescribed): ______ Y Y Y Y M M D D

4.2 Other (please describe): ______

4.3.1 Surgery date (past): Y Y Y Y M M D D

4.3.2 Surgery date (future): Y Y Y Y M M D D

4.4 Other treating physicians: ______

4.5 Is patient compliant with prescribed treatment? ☐ Yes ☐ No If no, please explain: ______

4.6 Has your patient been enrolled in a cardiac rehabilitation program? ☐ Yes ☐ No If yes, provide details:

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5. Restrictions and limitations

5.1 Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

5.2 Functional capacity:

Lifting/Carrying	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: ____ Duration: ____
Pushing/Pulling	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: ____ Duration: ____
Standing: ____ hours Walking: ____ blocks Driver's license revoked: ☐ Yes ☐ No		Frequency: ____ Duration: ____

5.3 What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? ____

5.4 How does this affect the patient's ability to perform activities of daily living? ____

6. Return to work plans

6.1 Prognosis for medical recovery: ____

6.2 Expected date patient will return to their own occupation: Y Y Y Y M M D D

6.3 If unknown, please indicate the next follow up date: Y Y Y Y M M D D

6.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work:

7. Assessment and treatment are complicated by: please select and explain in the space provided below

7.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

7.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

7.3 ☐ Work-related issues (please describe if known): ____

7.4 ☐ Substance abuse

7.5 ☐ Other (please describe):

8. Progress

8.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

8.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No

If yes, please specify: ____

9. 2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify: ____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements? ____

11. Identification of physician

11.1 First and last names (PLEASE PRINT)

11.2 Specialty | License no.

11.3 Address - No., street, office | City | Province | Postal code

11.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: **Date:**

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GROUP INSURANCE - DISABILITY CLAIMS

Initial Attending Physician's Statement
Cancer form

- A PLEASE PRINT.
- B PART 1 to be completed by patient.
- C PART 2 to be completed by physician.
- D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

First and last names (PLEASE PRINT)
Date of birth YYYY MM DD

Address - No., street, apt. | City | Province | Postal code

Telephone no. ( ) - | Contract no. | Certificate no.

PART 2 - Attending physician's statement

It can be very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including any complications). Please attach a copy of all consultation, operative and pathology reports.

1.1 Date of cancer diagnosis: Y Y Y Y M M D D

1.2 Site of the tumour: ______

1.3 Type of tumour: ______

1.4 Histology and staging:

2. History

2.1 Date symptoms first appeared: Y Y Y Y M M D D

2.2 Has this patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment: ______

2.3 Describe current symptoms: ______

2.4 First visit for these symptoms: Y Y Y Y M M D D

2.5 Current height: ______ Current weight: ______ Weight loss/gain to date: ______

2.6 In your opinion, when did the patient's condition first prevent them from working? Y Y Y Y M M D D

3. Treatment

3.1 Date of first visit: Y Y Y Y M M D D

3.2 Date of latest visit: Y Y Y Y M M D D

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): ______

3.4 Treatment - Include information on all treatments to date and future treatment plan, inclusive of:

a) Surgery: ______

b) Radiation: ______

c) Hormones: ______

d) Chemotherapy:

4. Hospitalization (if applicable for this illness or injury)

4.1 Date of in-patient admission: Y Y Y Y M M D D

4.2 Date of discharge: Y Y Y Y M M D D

4.3 Date of out-patient treatment: Y Y Y Y M M D D

4.4 Name of hospital:

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5. Therapies

5.1 Describe the therapies to date: ☐ N/A ☐ Partial ☐ Complete

5.2 Describe all co-morbid conditions: ____________________

5.3 Describe any post therapy sequelae: ____________________

5.4 Please provide the patient's prognosis for improvement and/or recovery: ____________________

5.5 Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

6. Patient's current physical abilities

6.1 Please indicate your patient's current physical abilities:

☐ Sedentary duties: Mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light duties: Frequent handling of loads of up to 5 kg, sometimes up to 11 kg; may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium duties: Frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy duties: Frequent handling of loads up to 23 kg, sometimes up to 45 kg.

6.2 In your opinion, what is the earliest date your patient will be able to return to work? Y Y Y Y M M D D

6.3 If the previous job could be modified, when could rehabilitation employment commence? Y Y Y Y M M D D

7. Comments

7.1 Please provide the names of other physicians who have been/will be involved in assessing the medical problems **and copies of any available consultation reports.** ____________________

7.2 We would appreciate any additional comments that would help us to better understand your patient and their condition. ____________________

8. Identification of physician

8.1 First and last names (PLEASE PRINT)			
8.2 Specialty			License no.
8.3 Address - No., street, office	City	Province	Postal code
8.4 Telephone no.: ( ) -		Fax no.: ( ) -	
Signature of physician:		**Date:**	