canada life

Physician's initial statement

Disability claim

1. Patient information

1.1 Policy numbers: _____

1.2 Name of insured: _____

1.3 Date of birth (day/month/year): _____

1.4 Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

1.5 Phone number: _____

2. Physical diagnosis

2.1 Primary diagnosis: _____

2.2 Secondary and complications: _____

2.3 Objective medical findings, including results of all diagnostic tests:

_____

2.4 Physical impairment, select one:

- ☐ Class 1 no limitation, capable of strenuous physical activity
- ☐ Class 2 slight limitation, capable of moderate activity
- ☐ Class 3 moderate limitation, capable of light activity
- ☐ Class 4 marked limitation, capable of minimal activity
- ☐ Class 5 severe limitation, incapable of minimal activity

3. Psychiatric diagnosis (DSM 5)

3.1 Primary diagnosis: _____

3.2 Secondary and complications: _____

3.3 Severity of psychosocial stressors (0 – non-existent; 1 – mild; 3 – moderate; 5 – severe)
Select one: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3.4 Factors that may have contributed to the onset of the clinical problems or may complicate their resolution:

- ☐ Workplace issues
- ☐ Personality or motivation
- ☐ Financial or legal problems
- ☐ Physical or medical conditions
- ☐ Coping skills
- ☐ Social or family issues
- ☐ Alcohol or drug abuse
- ☐ Other issues: _____

Evidence required

In order to consider this claim, please provide copies of all medical evidence regarding the investigation, diagnosis and treatment of this condition including test results, laboratory results, surgical reports and consultation reports.

4. Symptoms

4.1 On what date did your patient first have symptoms? (day/month/year) _____

4.2 From what date did the medical condition prevent the patient from working?
(day/month/year) _____

4.3 Has the patient ever had the same or similar condition?
☐ Yes, provide the date (day/month/year): _____
☐ No

4.4 Did you recommend the patient to stop work?
☐ Yes, provide the date (day/month/year): _____
☐ No

4.5 List the current symptoms and their degree of severity.

Symptom 1: _____ ☐ Mild ☐ Moderate ☐ Severe
Symptom 2: _____ ☐ Mild ☐ Moderate ☐ Severe
Symptom 3: _____ ☐ Mild ☐ Moderate ☐ Severe
Symptom 4: _____ ☐ Mild ☐ Moderate ☐ Severe
Symptom 5: _____ ☐ Mild ☐ Moderate ☐ Severe
Symptom 6: _____ ☐ Mild ☐ Moderate ☐ Severe

5. Treatment

5.1 Was the patient hospitalized? ☐ Yes, provide details below ☐ No

Name of institution: _____

Admittance date (day/month/year): _____ Discharge date (day/month/year): _____

5.2 If surgery was or will be performed, provide the date (day/month/year) and description of surgery:

_____

5.3 What is the nature of the current treatment (example: special programs, therapies, etc)?

5.4 Medication (attach a list of the medications if more than three):

Name: _____ Date started (day/month/year): _____ Frequency: _____
Name: _____ Date started (day/month/year): _____ Frequency: _____
Name: _____ Date started (day/month/year): _____ Frequency: _____

5.5 Has a specialist referral been made? ☐ Yes, provide details below ☐ No

Name of physician: _____ Specialty: _____
Date of referral (day/month/year): _____
Date of first visit (day/month/year): _____

Name of physician: _____ Specialty: _____
Date of referral (day/month/year): _____
Date of first visit (day/month/year): _____

5.6 Indicate the response to the treatment program to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

5.7 What is the prognosis for recovery: _____

5.8 Is the patient following the recommended treatment program? ☐ Yes ☐ No

5.9 Are there any other changes in the patient's treatment plan being considered or underway? ☐ Yes ☐ No

Provide details: _____

6. Return to work

6.1 Has a return to work plan been established?

☐ Yes, what is the expected return to work date (day/month/year): _____

Select one: ☐ Full time ☐ Part time ☐ Gradual

If a return to work is part-time or gradual, what is the recommended work schedule:

_____

☐ No, when will the patient be assessed for a possible return to work (day/month/year): _____

7. Other

7.1 Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work plan?

☐ Yes, provide details: _____

☐ No

8. Physician information and signature

8.1 Name of physician: _____

8.2 Specialty: _____

8.3 Phone number: _____ Fax number: _____

8.4 Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Date signed (day/month/year): _____

X _____

Signature of **physician**

- The patient is responsible for any fees related to the completion of this form and any other medical information provided.
- Mail, email or fax to:

  The Canada Life Assurance Company
  Living Benefits Claims
  PO Box 6000, Winnipeg MB R3C 3A5
  Email: lbclaims@canadalife.com
  Fax: 1-204-946-4030