Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

DISABILITY BENEFITS ATTENDING PHYSICIAN'S STATEMENT GENERAL

To allow us to make an assessment of your patient's claim, please answer all of the questions in full.

Instructions:
1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

Part 1: Patient Authorization

Policy Number: | Certificate Number: | Claim Number:

Name | Date of Birth DD / MM / YYYY

Address (number, street, city, province and postal code)

Phone Number (include area code)

I hereby authorize the release to Equitable Life of Canada® any information requested by Equitable Life of Canada in respect of this claim.

Patient's Signature | Date DD / MM / YYYY

Part 2: Attending Physician's Statement

1. Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports on file)

Primary:

Secondary:

Subjective Symptoms (including severity, frequency, duration):

Objective Findings (please enclose copies of current imaging reports, EKGs, Laboratory Data): If not provided, a decision on your patient's claim may be delayed.

2. History (please attach a copy of your clinical notes relating to this period of disability)

Date symptoms first appeared or accident happened: DD / MM / YYYY

Date patient stopped working due to this condition: DD / MM / YYYY

Has patient ever had same or similar condition? ❑ Yes ❑ No ❑ Unknown

If yes, please specify diagnosis and dates of treatment:

Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown

Have you completed Workers' Compensation forms? ❑ Yes ❑ No ❑ Unknown

188(2011/05/02)

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If patient is pregnant, give EDC | DD / MM / YYYY

Current height | Current weight | Weight loss/gain in past 6 months

3. Treatment Dates

Date of first visit for current condition: DD / MM / YYYY

Date of most recent visit: DD / MM / YYYY

Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (specify)

Date of hospital in-patient admission: DD / MM / YYYY

Date of discharge: DD / MM / YYYY

Date of hospital out-patient admission: DD / MM / YYYY

Name of hospital:

4. Nature of Treatment

Medications (dose, frequency, date prescribed)

Surgeries (including dates)

Other (including frequency)

Is patient following recommended treatment program? ❑ Yes ❑ No (please elaborate)

5. Progress

Has patient: ❑ Recovered ❑ Improved ❑ Not Improved ❑ Retrogressed since the patient stopped working

If the patient's condition has not improved/recovered, why not?

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6. Restrictions and limitations (if applicable)

LIFTING

Under 10 pounds ❑

10-20 pounds ❑

20-50 pounds ❑

Over 50 pounds ❑

CARRYING

Under 10 pounds ❑

10-20 pounds ❑

20-50 pounds ❑

Over 50 pounds ❑

REACHING

Above shoulder height ❑

At shoulder height ❑

Below shoulder height ❑

Sitting _____ hours		Pushing/Pulling _____ hours	
Standing _____ hours		Gripping _____ hours	
Walking _____ hours		Pinching _____ hours	

7. Mental/Nervous Impairment (if applicable)

History:

Are work related issues contributing to your patient's condition?

Changes in ADL habits

Familial risk factors

Progress with treatment plan

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:

Has your patient ever been enrolled in a substance abuse program? ❑ Yes ❑ No If yes, state when

8. Competency

Do you believe patient is competent to cash cheques and use the proceeds? ❑ Yes ❑ No

If no, why not?

Have you referred the case to the Public Trustee? ❑ Yes ❑ No

Have any referrals been made to specialists or other treatment providers? ❑ Yes ❑ No

If yes, please provide name and address of doctor referred to and appointment date.

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9. Return to work plans

Prognosis for recovery:

Expected date patient will return to their regular occupation: DD / MM / YYYY

If your patient is unable to return to their regular occupation at this time, please specify when and under what circumstances they could return to their regular occupation or another occupation.

Other factors affecting a return to work to their regular occupation or any occupation:

10. Rehabilitation

Is your patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc.)

❑ Yes ❑ No If yes, please specify. If no, why not?

Is patient a suitable candidate for vocational rehabilitation? ❑ Yes ❑ No

If yes, please specify:

11. 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?

12. Have you completed other requests regarding your patient's current medical condition to other sources, i.e. other insurance providers, Canada Pension Plan, WSIB/WCB, etc.? ❑ Yes ❑ No

If so, please provide details:

Name of Physician (please print)

Specialty:

Telephone: Fax:

Address (number, street, city, province & postal code):

Physician's signature Date:

Please keep a copy of this form for your records. **Please do not use staples.** Send this completed form, along with any other pertinent documentation, to:

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Alternatively, you can **scan** and **email** the forms to group-disability-claims@equitable.ca.
Or **fax** your documents to 519 883 7406 or fax toll free to 1 888 505 4373

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