Government of Canada | Gouvernement du Canada

PROTECTED *once completed*

Claim for Disability Insurance
Employee's Medical Information and Attending Physician's Statement
Policy No. 12500-G

For the Employee

To avoid delay, you must fully complete and sign Part 1 of this form, and have your doctor complete Part 2. **Please keep Part 1 attached to Part 2**. Your doctor should send this completed form to Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), at the address provided at the end of this form. You are responsible for the cost of completing this form.

PART 1: EMPLOYEE INFORMATION

About you

Last Name	Given Name		Maiden Name (for Quebec residents)
Street Address			Home Telephone No. ( )
City	Province	Postal Code	Date of Birth (Day / Month / Year) / /
Sex ☐ Male ☐ Female ☐ Ms. ☐ Mrs. ☐ Miss		Certificate No. CG-	

About your illness or injury

1. Please describe your present illness or injury and how it prevents you from working. Include a description of the duties of your job that you are **unable** to perform because of your illness or injury. (Attach extra sheets, if necessary.)

____

____

2. When did your symptoms first appear? Day / Month / Year

3. Have you ever had the same symptoms or a similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

____

4. On what date did you first see a doctor for this illness or injury? Day / Month / Year

5. On what date did you become totally unable to perform the duties of your own occupation? Day / Month / Year

6. Have you had to change your daily activities because of your illness? ☐ No ☐ Yes

If yes, please describe your daily activities before you became ill and your daily activities now. (Attach extra sheets, if necessary.)

Activities before you became ill:

____

____

____

Activities now:

____

____

7. What treatment(s) are you currently receiving (medicine, diets, advice from a doctor, physiotherapy, psychotherapy, etc.)?

____

____

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About your illness or injury (continued)

8. Do you have a valid driver's licence?

☐ No
☐ Yes

If your driving has been restricted as a result of your illness or injury, please give details. Please also explain how you get around when you leave your house (i.e. drive, public transport, taxi, etc.).

____

____

9. Provide the names and addresses of all the doctors you consulted during your present illness or injury.

Name of doctor	Address	Date of visit

Your general medical history

Attach extra sheets, if necessary.

1. List all the doctors you have consulted during the past five years.

Name of doctor	Address	Nature of illness / injury	Treatment prescribed (medicine, diet, etc.)	Date of visit / treatment

2. Please list the names and addresses of all the hospitals where you received treatment during the past five years, including any type of surgery.

Nature of illness / injury	Date of visit or confinement	Treatment or surgery (medicine, diet, etc.)	Name and address of hospital

If, as a result of any of these prior illnesses or injuries, changes in activities or work restrictions were advised, please describe what the changes were:

Employee's declaration, authorization and signature

- I certify that the statements on this form are true and complete.
- I authorize my doctor, Sun Life Assurance Company of Canada and any person or organization who has relevant personal information about me, including health professionals and institutions, investigation agencies, insurers and persons performing services for Sun Life Assurance Company of Canada, to exchange information needed for underwriting, administration or paying claims.
- I agree to a personal investigation in connection with this claim.
- I agree that a photocopy of this authorization is as valid as the original.

Employee's Signature	Date

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PART 2: ATTENDING PHYSICIAN'S STATEMENT

Medical History

Please fill in this form completely and as soon as possible to ensure that there is no delay of any payments to which the employee may be entitled. Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), will use the information on this form to determine the employee's eligibility for disability benefits. Your accurate and detailed completion of this form will help the Insurer to arrive at a just decision. The Insurer may request up-to-date medical or fitness information from you to review the employee's progress and potential to return to work. The employee is responsible for the cost of completing this form.

1. What was the date of the patient's first appointment for this illness or injury? Day / Month / Year

2. What was the date of the patient's latest appointment? Day / Month / Year

3. Did you recommend that the patient stop work? ☐ No ☐ Yes If yes, as of what date? Day / Month / Year

4. How often are the patient's appointments? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (Please specify.) ______

5. Was the patient's illness or injury caused by an accident? ☐ No ☐ Yes

If yes, please give the details and the date of the accident.

______

______

6. Describe the pertinent symptoms, their severity, their duration and their impact on the claimed disability (including the patient's ability to work).

______

______

7. When did the symptoms first appear? Day / Month / Year

8. Has the patient ever had a similar or related condition? ☐ No ☐ Yes If yes, state when and describe the condition.

______

______

9. Is the condition due to injury or illness caused by employment? ☐ No ☐ Unknown ☐ Yes If yes, give details.

______

______

10. Is the condition due to or related to pregnancy? ☐ No ☐ Yes If yes, give dates of confinement.

From Day / Month / Year **to** Day / Month / Year

11. How is the patient restricted or limited by the condition?

______

______

______

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Medical History (continued)

12. What is the patient's current status?

☐ Ambulatory ☐ Using a walking aid ☐ Using a wheelchair
☐ House confined ☐ Bed confined ☐ Hospital confined

13. Please indicate the patient's current height and weight.

Height: ______ Weight: ______

Clinical findings

Please describe the physical findings in relation to the illness or injury.

Diagnoses

What are the diagnoses that have led to the disability claim? Please list them in order of their importance to the patient's illness or injury and their impact on the claimant. If the condition is psychiatric, use DSM IV terminology.

Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the illness or injury. (Attach available consultation notes.)

Treatment

1. Was this patient hospitalized? ☐ No ☐ Yes If yes, give dates:

From Day / Month / Year **to** Day / Month / Year

2. Was surgery performed or is it scheduled? ☐ No ☐ Yes If yes, give details:

Date	Type of Surgery

3. What medications were prescribed to the patient? Please include names, dates first prescribed, dosage and the dates of any medication changes.

Treatment (continued)

4. Has the patient been given counselling or psychotherapy?

☐ No
☐ Yes

If yes, give frequency and duration.
(Attach copies of reports.)

____
____
____

5. Has the patient received physiotherapy/chiropractic treatment?

☐ No
☐ Yes

If yes, give frequency and duration.
(Attach copies of reports.)

____
____
____

6. What other treatments have been or are being given?

____
____

7. Please describe the result of all treatments to date.

____
____

8. To what extent has the patient complied with the treatment plan? Please explain any factors that may have prevented compliance.

____
____

9. Please give names, specialties and appointment dates of any consulting physicians or health care professionals such as psychologists.
(Attach copies of consultation notes.)

Name and Address	Specialty	Appointment date

Cardiac Complete if applicable.

1. What is the functional capacity (American Heart Association)? If Class 3 or 4, please include a copy of stress test or cardiac echogram.

☐ Class 1 (no limitation)
☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)
☐ Class 4 (complete limitation)

2. What is the latest blood pressure reading for the patient?

/

3. Date blood pressure reading recorded:

Day / Month / Year

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Vocational rehabilitation and return to work information

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?

☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

2. Please describe the patient's functional restrictions (physical or psychological), if any.

3. Over what period of time can recovery of usual functional abilities be anticipated?

☐ 1-3 months ☐ 4-6 months ☐ 7-9 months ☐ over 9 months

4. If a specific date of recovery for work is anticipated, please indicate it. Day / Month / Year

5. Have you scheduled a reassessment for this patient? ☐ No ☐ Yes If yes, give date. Day / Month / Year

6. Do you foresee this patient as a potential candidate for vocational rehabilitation:

Now: ☐ No ☐ Yes

Future: ☐ No ☐ Yes If yes, please explain:

7. Please describe any other factors that may affect this patient's ability to return to work.

8. Please comment on the patient's willingness to return to work.

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Additional information

1. In your opinion, does the patient have any physical or mental limitations that would prevent him/her from handling his or her own financial affairs?

☐ No
☐ Yes

If yes, give details of any physical or mental limitations.

____

____

____

2. Would further communication with the Insurer's Medical Director be beneficial?

☐ No
☐ Yes

3. Would it be helpful for you to speak with a Rehabilitation Specialist representing the Insurer?

☐ No
☐ Yes

Physician information

Name (Please print.)		
Street Address		
City	Province	Postal Code
Specialty	Telephone No. ( )	Fax No. ( )

Physician Signature

Signature	Date

To keep this document confidential, please send this form to the Sun Life Assurance Company of Canada Claims Office listed below:

Montreal Group Disability Management Office
Federal Government Disability Insurance Plan
PO Box 12500 Stn CV
Montreal, QC H3C 5T6

Provision of the information requested in this form is voluntary. The information is being collected by the Insurer for the purpose of the administration and the assessment of claims under the Disability Insurance Plan. This information is essential to the Insurer's decision concerning this claim. Refusal to respond fully may result in disability benefits not being approved. All information provided is strictly confidential, for use by the Insurer, in connection with the Disability Insurance Plan.