Equitable Life of Canada®

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ATTENDING PHYSICIAN'S STATEMENT DISABILITY BENEFITS
(or at the insurer's option such other benefits as the insurer may wish to state)

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
Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Part 1: Patient Authorization	Policy No:
Name	Date of Birth *(day, month, year)*
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 file.

Patient's Signature Date *(day, month, year)*

Part 2: Attending Physician's Statement

Any charge for completing this form is the patient's responsibility. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

1. **History**

a) Date symptoms first appeared or accident happened (day, month, year)	b) Date patient ceased work because of current condition (day, month, year)	c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

d) Have you completed other requests regarding your patient's current medical condition to other sources, i.e. other insurance providers, Canada Pension Plan, provincial workers compensation plan, etc.? ☐ Yes ☐ No
If "Yes", please provide details:

e) Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes, state and describe	f) Is condition considered chronic? ☐ No ☐ Yes, what precipitated absence from work

g) Names of other treating physicians or health care providers

2. **Diagnosis** *(including any complication)*

a. Primary

b. Additional conditions or complications which might affect duration of absence from work

c. Objective signs (Please attach copies of current x-rays, EKGs, laboratory data and any relevant clinical findings that support your diagnosis)

d. Subjective symptoms

e. Are patients symptoms related to drug, alcohol or other substance abuse? ☐ No ☐ Yes

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3. Indicate your patients functional capacity below for each question by checking "R" for Restriction (what your patient should not do) or "L" for Limitation (what your patient is unable to do).

Lifting Under 11lbs (4.98 kg) R ☐ L ☐ 11-22 lbs (4.98-9.97 kg) R ☐ L ☐ 22-24 (9.97- 10.88 kg) R ☐ L ☐ Over 44 (19.95 kg) R ☐ L ☐

Carrying Under 11lbs (4.98 kg) R ☐ L ☐ 11-22 lbs (4.98-9.97 kg) R ☐ L ☐ 22-24 (9.97- 10.88 kg) R ☐ L ☐ Over 44 (19.95 kg) R ☐ L ☐

Reaching Above shoulder height R ☐ L ☐ At shoulder height R ☐ L ☐ Below shoulder height R ☐ L ☐

Sitting	hours	Overhead Lifting	hours
Standing	hours	Pushing/Pulling	hours
Walking	hours	Gripping	hours
Pinching	hours	Keyboarding	hours

Cognitive Demands please check Yes or No in the applicable spaces below

Comprehension	☐ Yes ☐ No	Information processing	☐ Yes ☐ No
Visual perception	☐ Yes ☐ No	Memory	☐ Yes ☐ No
Attention	☐ Yes ☐ No	Other	☐ Yes ☐ No

Please indicate what (if any) modified duties and/or hours are available for this Employee:

4. **Mental/Nervous Impairment** *(if applicable)*

a) How does patient's mental or nervous impairment affect ability to work?

b) Has there been psychiatric referral?
☐ Yes ☐ No

c) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?
☐ Yes ☐ No

5. **Cardiac** *(if applicable)*

a. Functional capacity: (Canadian Cardio-Vascular Society (CCS))

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

Please forward results of exercise stress tests, angiogram or other relevant documentation.

b. Blood pressure *(last visit)*

Systolic	Diastolic

6. **Treatment**

a. Date of first visit *(day, month, year)*

b. Date of latest visit *(day, month, year)*

c. Frequency of visits
☐ Weekly ☐ Monthly
☐ Other *(specify)*

d. Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*

e. To your knowledge is patient following recommended treatment program?
☐ Yes ☐ No, please comment

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7. **Progress**

Has patient ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

8. **Prognosis**

(a) Please provide prognosis for a partial or full recovery.

(b) In your opinion, what job modifications are required to support this patient in returning to work?

(c) Do you anticipate this patient will not be able to become gainfully employable?

9. **Rehabilitation**

a. Is patient a suitable candidate for further medical rehabilitation service *(ie. cardiopulmonary program, speech therapy, etc.)*?
☐ No ☐ Yes

b. Would vocational counselling and/or retraining be recommended?
☐ No ☐ Yes

10. **Remarks – Please provide comments and further details which you feel would be helpful.**

Name of attending physician *(please print)*	Specialty	Telephone No. ( )
Address *(number, street, city, province, postal code)*		
Signature	Date *(day, month, year)*	

Fax this completed form, along with any other pertinent documentation to 1.888.505.4373
or mail to (do not use staples):

Equitable Life of Canada
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn Waterloo, Waterloo Ontario N2J 4C7

Please keep a copy of this form for your records.

Please note: Equitable Life cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.265.4556.