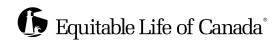


Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo, Ontario N2J 4C7
TF 1.800.668.4095 T 519.886.5210
www.equitable.ca

## 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 Incomplete responses	patient 3. Part 2 to be complor missing information will caus	leted by physician 4. Any c se delays in the assessment ar	charge for completing this form is the patient's responsibility 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	of Canada® any informa	ition requested by Equi	itable 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	nt's responsibility. Incomplete res	sponses or missing informatio	on will cause delays in the assessment and handling of this file.					
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?					
<ul> <li>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:</li> </ul>								
e) Has patient ever had same or similar co	ndition? and describe	f) Is condition considered chronic?  □ No □ Yes, what precipitated absence from work						
g) Names of other treating physicians or h	ealth 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? $\square$ No $\square$ Yes								

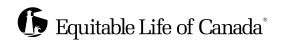




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(or at the insurer's option such other benefits as the insurer may wish to state)

			city below for each qu at your patient is unab		checking "R" for	Restriction (what	your patient
Lifting	Under 11lbs (4.9	28 ka) R □ L □ 11-22	, . 2 lbs (4.98-9.97 kg) R □	L 🗆 22-24	(9.97- 10.88 ka)	R □ L □ Over 44	(19.95 ka) R □ L □
Carrying		3	2 lbs (4.98-9.97 kg) R □				
Reaching			At shoulder height R□				
Sitti	ng	hours Ove					
Standing		hours Push		ing/Pulling		hours	
Wa	lking	hours <b>Grip</b> r		ping		hours	
Pinching		hours	Keyboarding		hours		
Cogni	itive Demands ple	ase check Yes or No	in the applicable spaces	below			
	Comprehension	☐ Yes ☐ No	Information proces	sing $\square$ Ye	s 🗆 No		
	Visual perception	☐ Yes ☐ No	Memory	□Y∈	s 🗆 No		
	Attention	☐ Yes ☐ No	Other	□Y∈	s 🗆 No		
	as there been psyc	chiatric referral?				is competent to enduse of proceeds then	
<ul><li>5. Cardiac (if applicable)</li><li>a. Functional capacity: (Canadian Cardio-Vascular Society (CCS))</li></ul>		b. Blood pressure (last visit)					
[ 	□ Level 1 (no limitation) Please forward resu	☐ Level 2 (mild impairme lts of exercise stress tes	☐ Level 3 ent) (moderate impai sts, angiogram or other rele		vere impairment)	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. 1	Nature of treatmen	nt (including surgery, ph	hysiotherapy and medication	ns prescribed	if any)	1	
	,	e is patient following  No, please comme	recommended treatment	program?			





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

7.	7. Progress							
	Has patient ☐ Recovered ☐ Improved	☐ Not improved		Retrogressed				
8.	ognosis							
	(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. <b>Rehabilitation</b>								
	a. Is patient a suitable candidate for further medical rehabilitation service (ie. cardiopulmonary program, speech therapy, etc.)?							
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.								
	,	•						
NI.	Name of annual constraint ( )			Talankana Nia				
INO	Name of attending physician (please print)  Sp	pecialty		Telephone No. ( )				
Ad	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.	
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