Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

the co-operators
A Better Place For You®

Attending Physician's Statement - Short Term Disability Claim

Plan Member/Employee Information and Consent (To be completed by Plan Member)

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (Include Area Code)	Cell Phone # (Include Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Plan Contract Number	Plan Member Certificate Number

Height	Weight	Date of Birth (dd/mm/yyyy)

Last Date Worked	**Date Returned to Work or Expected Return to Work Date**

I hereby authorize the release of medical and health information in my file to _____(the insurance company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

_____ _____

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

Attending Physician's Statement

NOTICE TO PHYSICIAN:

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

Diagnosis
Primary:

Secondary:

If Childbirth: Expected or Actual Delivery Date

_____

Vaginal ☐ C-Section ☐

Occupational Illness/injury
Is condition arising from employment? Yes ☐ No ☐

Date of first visit pertaining to this illness (dd/mm/yyyy)	First date of work absence due to condition (dd/mm/yyyy)

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☐

Name of institution: _____

Date admitted (dd/mm/yyyy): _____

Date discharged (dd/mm/yyyy):_____

If surgery was performed please provide date and description of surgery
Date (dd/mm/yyyy) _____ Description: _____

Treatment (drug, dosage, physiotherapy, other):

Prognosis Please provide the prognosis for recovery:

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Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☐	If Yes, date (dd/mm/yyyy):

Describe current symptoms, severity and frequency:

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other_____

Please attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty_____ Date of Visit _____

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

To your knowledge, is the patient following the recommended treatment program? Yes ☐ No ☐

In your opinion, is your patient competent to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (Please Print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (Include Area Code)	Fax # (Include Area Code)	
Signature	Date (dd/mm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.