ATTENDING PHYSICIAN'S STATEMENT

IN THIS TEXT, THE MASCULINE GENDER MAY BE INTERPRETED AS THE FEMININE GENDER.

IT IS THE PATIENT'S RESPONSIBILITY TO HAVE THIS FORM COMPLETED AT HIS EXPENSE. YOU MAY MAIL IT TO **UL MUTUAL** OR HAND IT TO THE PATIENT. THANK YOU FOR YOUR COOPERATION.

CLAIM FOR DISABILITY INSURANCE BENEFITS

THIS DECLARATION IS TO PERMIT US TO ADEQUATELY ESTABLISH THE DEGREE OF DISABILITY. PLEASE GIVE DETAILED MEDICAL HISTORY, YOUR OBSERVATIONS, YOUR DIAGNOSIS, THE TREATMENT PRESCRIBED AND THE RESULTS OF SUCH TREATMENT.

NAME OF PATIENT (PLEASE PRINT)	DATE OF BIRTH D M Y	POLICY NUMBER

1. DIAGNOSIS (IF A PSYCHIATRIC ILLNESS, KINDLY STATE THE CODE AND AXIS AS PER THE « *DSM* »)

A. PRIMARY (INCLUDING ALL THE COMPLICATIONS):

_____

_____

B. SECONDARY (OR OTHER COMPLICATIONS THAT MAY AFFECT THE PERIOD OF DISABILITY):

_____

_____

C. SUBJECTIVE SYMPTOMS:

_____

D. OBJECTIVE SIGNS (recent results of X-RAYS, E.K.G.'s, laboratory data and any relevant clinical findings):

_____

2. HISTORY OF ILLNESS

A. DATE WHEN SYMPTOMS FIRST APPEARED OR DATE OF THE ACCIDENT DAY _____ MONTH _____ YEAR _____

B. DATE OF THE WORK STOPPAGE DUE TO THIS DISABILITY DAY _____ MONTH _____ YEAR _____

C. HAS THE PATIENT EVER SUFFERED FROM THIS CONDITION OR A SIMILAR CONDITION? YES ☐ NO ☐ DON'T KNOW ☐

IF YES, DATES AND DETAILS: DAY _____ MONTH _____ YEAR _____

_____

D. IS THIS A CHRONIC CONDITION? YES ☐ NO ☐ A RECURRING CONDITION? YES ☐ NO ☐

IF YES, WHAT IS THE CAUSE OFTHE ACTUAL WORK STOPPAGE? _____

E. IF THE PATIENT HAS SUFFERED FROM THIS CONDITION FOR SOME TIME,
WHAT IS THE PROGRESS OF HIS STATE OF HEALTH : STABLE ☐ IMPROVED ☐ SLIGHTLY DETERIORATED ☐ CONSIDERABLY DETERIORATED ☐

F. IS THIS CONDITION DUE TO A WORK-RELATED ACCIDENT OR PROFESSIONNAL ILLNESS? YES ☐ NO ☐ DON'T KNOW ☐

G. IS THIS CONDITION DIRECTLY OR INDIRECTLY DUE TO PREGNANCY? YES ☐ NO ☐

IF YES, EXPECTED DATE OF DELIVERY DAY _____ MONTH _____ YEAR _____

H. NAME AND SPECIALTY OF OTHER ATTENDING PHYSICIANS OR THERAPISTS (IF APPLICABLE, GIVE DETAILS IN SECTION 7 **COMMENTS**).

3. TREATMENT

A. DATE OF FIRST VISIT DAY _____ MONTH _____ YEAR _____

B. DATE OF LAST VISIT DAY _____ MONTH _____ YEAR _____

C. FREQUENCY OF VISITS WEEKLY ☐ MONTHLY ☐ OTHER ☐

D. TYPE OF TREATMENT AND ESTIMATED DURATION: _____

_____

E. NAME OF DRUGS AND POSOLOGY:_____

_____

F. WAS SURGERY INVOLVED? YES ☐ NO ☐ PENDING ☐ DATE : DAY _____ MONTH _____ YEAR _____

TYPE OF SURGERY: _____

G. HAS PATIENT BEEN OR IS HE TO BE HOSPILALIZED? YES ☐ NO ☐

IF YES, PERIOD AND NAME OF HOSPITAL OR REHABILITATION CENTER:

FROM _____ TO _____ NAME: _____

H. DOES THE PATIENT FOLLOW THE RECOMMENDED TREATMENTS? YES ☐ NO ☐ IF NO, GIVE DETAILS IN SECTION 7 **COMMENTS**.

4. PRESENT STATE OF HEALTH

CARDIAC (IF APPLICABLE)

A. FUNCTIONAL CAPACITY: NO LIMITATION ☐ SLIGHT LIMITATION ☐ MARKED LIMITATION ☐ COMPLETE LIMITATION ☐

B. BLOOD PRESSURE (LAST VISIT): SYSTOLIC/DIASTOLIC

PHYSICAL DISABILITY

A. ☐ NO LIMITATION, ABLE TO PERFORM ANY PHYSICAL ACTIVITY

B. ☐ SLIGHT LIMITATION, LIGHT MANUAL WORK NOT REQUIRING REPETITIVE MOVEMENTS

C. ☐ MODERATE LIMITATION, NORMAL WORK REQUIRING A MODERATE EXERTION WITH POSSIBLE REPETITIVE MOVEMENTS

D. ☐ MARKED LIMITATION; WORK REQUIRING SUSTAINED EXERTION

E. ☐ SEVERE LIMITATION; UNABLE TO PERFORM ANY WORK, EVEN SEDENTARY WORK

FOR LIMITATIONS ***C, D*** AND ***E*** KINDLY CHECK OFF THE FUNCTIONS WHICH ***CANNOT*** BE PERFORMED DUE TO THE PATIENT'S STATE OF HEALTH:

☐ RUNNING	☐ LIFTING WEIGHTS OVER _____ LBS/KG	☐ MAINTAINING BALANCE
☐ CLIMBING	☐ TRANSPORTING WEIGHTS OVER _____ LBS/KG	☐ DRIVING A MOTOR VEHICLE
☐ BENDING OVER	☐ KNEELING DOWN	☐ STARTING UP HEAVY EQUIPMENT

PSYCHOLOGIC STATE

A. ☐ THE PATIENT IS ABLE TO ADAPT TO STRESSFULL SITUATIONS AND TO FUNCTION IN SOCIETY

B. ☐ THE PATIENT IS ABLE TO ADAPT TO MOST STRESSFUL SITUATIONS AND TO FUNCTION IN SOCIETY IN ALMOST ANY SITUATION

C. ☐ THE PATIENT IS ABLE TO ADAPT TO SOME STRESSFUL SITUATIONS AND TO FUNCTION IN SOCIETY IN CERTAIN SITUATIONS

D. ☐ THE PATIENT IS INCAPABLE TO ADAPT TO STRESSFUL SITUATIONS NOR TO FUNCTION IN SOCIETY

E. ☐ THE PATIENT IS UNAWARE OF HIS DIFFICULTIES TO ADAPT PSYCHOLOGICALLY, PHYSIOLOGICALLY AND SOCIALLY

5. PROGNOSIS

A. IS THE PATIENT TOTALLY UNABLE TO PERFORM HIS REGULAR OCCUPATION? YES ☐ NO ☐

IF YES, WHEN WILL THE PATIENT BE ABLE TO RETURN TO WORK? DAY _____ MONTH _____ YEAR _____ NEVER ☐

IF NO, WHEN WAS THE PATIENT ABLE TO RETURN TO WORK? DAY _____ MONTH _____ YEAR _____

IF NO DATE HAS BEEN SET, GIVE AN ESTIMATE OF THE NUMBER OF ADDITIONAL WEEKS REQUIRED BEFORE THE RETURN TO WORK: _____ WEEKS

B. IS THE PATIENT ABLE TO PERFORM ANY OTHER REMUNERATIVE EMPLOYMENT? YES ☐ NO ☐

6. FUNCTIONAL REHABILITATION

A. WOULD A PROFESSIONAL REORIENTATION OR A REHABILITATION PROGRAM BE RECOMMENDED? YES ☐ NO ☐

B. DOES THE PATIENT'S STATE OF HEALTH ***PERMIT*** HIM TO RETURN TO WORK ON A PROGRESSIVE BASIS? YES ☐ NO ☐

C. IS THE PATIENT'S STATE OF HEALTH STABLE ENOUGH FOR A RETURN TO WORK ON A PARTIALLY PROGRESSIVE BASIS, FOR SHORT DURATIONS, PROVE TO BE ADEQUATE AND BENEFICIAL? YES ☐ NO ☐

IF YES, KINDLY GIVE YOUR RECOMMENDATIONS IN SECTION 7 **COMMENTS** AND GIVE REASON WHY A RETURN TO WORK ON A FULL-TIME BASIS SHOULD NOT BE ATTEMPTED?

7. COMMENTS

_____

_____

_____

_____

_____

_____

_____

NAME OF PHYSICIAN (PLEASE PRINT)	SPECIALTY

ADDRESS	TELEPHONE NUMBER

X

DATE **SIGNATURE OF PHYSICIAN**

I ACCEPT THAT ANY ADDITIONAL INFORMATION WITH REGARDS TO THIS REQUEST BE TRANSMITTED TO MY INSURER.

X X

DATE **NAME OF PATIENT (PLEASE PRINT)** **SIGNATURE OF PATIENT**

DISABILITY CLAIM

IMPORTANT: IF YOU ARE UNABLE TO WORK, YOU MAY QUALIFY FOR DISABILITY BENEFITS OF FOR A WAIVER OF YOUR PREMIUM. PLEASE COMPLETE AND REMIT THIS DOCUMENT TO THE INSURANCE COMPANY AS SOON AS POSSIBLE. THE INITIAL CLAIM MUST INCLUDE A DULY COMPLETED AND SIGNED CLAIMANT STATEMENT AND ATTENDING PHYSICIAN'S STATEMENT.

CLAIMANT STATEMENT

POLICE NUMBER	CONTRACT OR CERTIFICATE NUMBER	DIVISION / CLASS	N.A.S.

SURNAME OF EMPLOYEE	FIRST NAME	DATE OF BIRTH D	M	Y

ADDRESS

CITY	PROVINCE	POSTAL CODE

TELEPHONE AREA CODE			CAUSE OF DISABILITY

EFFECTIVE DATE	MONTHLY BENEFITS	DATE OF MONTHLY BENEFITS

	D	M	Y
EFFECTIVE DATE OF YOUR DISABILITY (LAST DAY OF WORK)			
DATE OF THE FIRST VISIT TO AN ATTENDING PHYSICIAN			

NAME AND ADDRESS OF THE ATTENDING PHYSICIAN _____

_____

APPROXIMATE DATE OF RETURN TO WORK	D	M	Y

HAVE YOU BEEN HOSPITALIZED? YES ☐ NO ☐ IF "YES", SPECIFY DURATION FROM _____ TO _____

NAME OF HOSPITAL _____

WAS YOUR DISABILITY THE RESULT OF AN ACCIDENTAL INJURY? YES ☐ NO ☐

IF YES, SPECIFY THE DATE OF THE INJURY	D	M	Y

TIME OF INJURY _____ A.M. ☐ P.M. ☐

SPECIFY THE PLACE AND CIRCUMSTANCES OF THE INJURY:_____

_____

HAVE YOU SUFFERED A SIMILAR DISABILITY IN THE PAST? YES ☐ NO ☐

IF YES, SPECIFY_____

DO YOU RECEIVE ADDITIONAL DISABILITY INCOME BENEFITS? YES ☐ NO ☐

IF YES, SPECIFY THE SOURCE _____ SINCE WHEN? _____

NAME AND ADDRESS OF YOUR CURRENT EMPLOYER: _____

_____

OCCUPATION: _____

NUMBER OF HOURS WORKED WEEKLY: _____

HAVE YOU SUBMITTED A CLAIM WITH THE FOLLOWING GOVERNMENT BODIES			DATE	ACCEPTÉD	REJÉCTED	PENDING
CANADA PENSION PLAN	YES ☐	NO ☐	_____	☐	☐	☐
QUÉBEC PENSION PLAN	YES ☐	NO ☐	_____	☐	☐	☐
CANADA EMPLOYMENT AND IMMIGRATION COMMISSION (C.E.I.C.)	YES ☐	NO ☐	_____	☐	☐	☐
COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL (C.S.S.T.)	YES ☐	NO ☐	_____	☐	☐	☐
SOCIÉTÉ DE L'ASSURANCE AUTOMOBILE DU QUÉBEC (S.A.A.Q.)	YES ☐	NO ☐	_____	☐	☐	☐
OTHER ORGANISATION OR INSURER	YES ☐	NO ☐	_____	☐	☐	☐

PLEASE PROVIDE ALL DOCUMENTS PERTINENT TO THE CLAIM.

AUTHORIZATION

I HEREBY CERTIFY THAT THE ABOVE MENTIONED INFORMATION AND ANSWERS ARE COMPLETED AND TRUE. I AUTHORIZE ANY PHYSICIANS, HOSPITALS, MEDICAL CLINICS, INSURANCE COMPANIES OR OTHER ORGANISATION INCLUDING THE C.S.S.T., THE S.A.A.Q., C.E.I.C OR ANY PERSON OR INSTITUTION HOLDING INFORMATION OF ME, MEDICALLY OR FINANCIALLY, TO PROVIDE THIS INFORMATION TO **UL MUTUAL.** A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

X		X
DATE	**NAME OF POLICYHOLDER (PLEASE PRINT)**	**SIGNATURE**

MUTUAL

AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

In order to assess insurability, maintain our file and claims assessment, we authorize any person or institution holding personal information about us including any health information, medical history or eligibility for claims, to transmit such information to UL Mutual or its reinsurers upon request. This includes doctors or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, the Medical Information Bureau, personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, the Commission de santé et sécurité du travail or other Workmen's Compensation Board, Canada or Quebec Pension Plan, Régime de rentes du Québec , Société de l'assurance automobile du Québec or other Department of Motor Vehicles, la Régie de l'assurance médicaments du Québec or other provincial Health Department, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Likewise, we authorize UL Mutual to transmit the information to its reinsurers as well as to a third party. For the same purpose and to gather the same type of information, we also authorize UL Mutual or its reinsurers to request an investigative report about us and to use information in their possession in other files. This consent is also valid for gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this consent will affect its content nor bind the insurer. This consent may also be used for a request for additional insurance or a contract modification.

A photocopy of this agreement shall be as valid as the original.

Signed at _____, this _____ 20 _____

X _____
WITNESS

X _____
SIGNATURE

ADDRESS _____

_____

_____