




Group Benefits

Attending Physician's Statement

Short Term Group Disability Claim

Your patient would appreciate the completion of this form as soon as possible, otherwise, there may be a delay in the processing of this claim.
Please keep a copy for your records.

Return completed form to:

1 Plan member/employee information and consent (To be completed by patient.)			
Plan member/employee name (last, first, middle initial)		Home phone number () ()	Cell phone number () ()
Address (number, street, apt.)		City	Province Postal code
Plan sponsor name		Plan contract number	Plan member certificate number
Height	Weight	Date of birth (dd/mmm/yyyy)	
Last date worked (dd/mmm/yyyy)		Date returned to work or expected return to work date (dd/mmm/yyyy)	
<p>I hereby authorize the release of any medical information in my file to the Manufacturers Life Insurance Company ("Manulife Financial") for the purpose of assessing my disability claim and administering the benefits plan. This medical 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.</p>			
Plan member/Employee signature _____		Date (dd/mmm/yyyy) _____	
2 Attending physician's statement			
	<p>NOTE TO PHYSICIAN:</p> <ul style="list-style-type: none"> • If your patient has returned to work or will return to work within 4 weeks of the <i>last date worked</i>, complete section 2 only and sign at the end of the form. • For absences expected to be greater than 4 weeks, please complete all sections in full. 		
Diagnosis			
Primary:			
Secondary:			
			If childbirth provide expected or actual delivery date (dd/mmm/yyyy) _____
Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>			
Occupational illness/injury			
Is condition arising from employment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date of first visit pertaining to this illness (dd/mmm/yyyy)		First date of work absence due to condition (dd/mmm/yyyy)	
Hospitalization			
Is/was patient hospitalized <input type="checkbox"/> or had day surgery <input type="checkbox"/>		Date admitted (dd/mmm/yyyy): _____	
Name of institution: _____		Date discharged (dd/mmm/yyyy): _____	
If surgery was performed provide date and description of surgery.			
Date (dd/mmm/yyyy): _____		Description: _____	
Treatment (drug, dosage, physiotherapy, other)			
Prognosis Please provide the prognosis for recovery			

3 Continuation of attending physician's statement for absences that may be greater than 4 weeksHas the patient been treated for this condition in the past? Yes No If Yes, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of Visits Weekly Monthly Other _____**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 previously completed in section 2)**4 Physician's acknowledgement and authorization**

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life Insurance Company ("Manulife Financial") 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 specialist

Physician's stamp

Address (number, street, suite)

City

Province

Postal code

Telephone number

()

Fax number

()

Signature

Date signed (dd/mmm/yyyy)

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