



# Initial Attending Physician's Statement

- Long Term Disability Claim
- Waiver of Premium Claim for:
  - Basic & Optional Life Benefit
  - AD&D Benefit
  - Survivor Benefit

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*An incomplete form may result in delays in the adjudication of your patient's disability claim.*

*Please see page 2 for instructions.*

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*Please select the appropriate Regional Claim Office address for this claim:*

- Calgary
- Halifax
- Montreal
- Toronto
- Vancouver
- Waterloo
- Winnipeg

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**The LTD eligibility process**

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

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**Patient authorization**

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 3 before it can be submitted to Manulife Financial.

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**What do we need from you?**

- We need you to print clearly and answer all applicable questions.
  - We need you to provide copies of consultation, progress and diagnostic investigation reports.
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**Payment responsibility**

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

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**Submitting forms**

You may give the completed form to your patient or send it directly to Manulife Financial, Group Disability Benefits, at the address indicated below.

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# Group Benefits

## Initial Attending Physician's Statement

### Group Disability Claim

#### 1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Plan contract number	Plan member certificate number
<p>"I hereby authorize the release to Manulife Financial of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. <b>I understand that I am responsible for any fees related to the completion of this form.</b>"</p>		
Patient's signature	Date (dd/mmm/yyyy)	

#### 2 Attending physician's statement

##### Diagnosis

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) **If** psychiatric disorder, provide current GAF score.

GAF score

d) **If** cardiac disorder, provide American Heart Association functional classification.

Class I (No limitation)       Class II (Slight limitation)  
 Class III (Marked limitation)       Class IV (Complete limitation)

#### 3 Clinical information

**Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results in support of your patient's diagnosis and functional abilities.**

a) What date did symptoms first appear/accident happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

Injury       Work-related       Motor vehicle accident       Other (specify)  
 Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)      Date of latest visit (dd/mmm/yyyy)

Frequency of visits

Weekly       Bi-weekly       Monthly       Other (specify)

e) What are the patient's subjective **symptoms**?

f) How have **symptoms** evolved to date? (Please indicate frequency and severity)

g) What were your initial **clinical findings**?

h) What are your most recent **clinical findings**?

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

- Ambulatory                       Bed confined                       Hospital confined  
 Ambulatory with assistive devices                       Home confined

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand <input type="radio"/> Left <input type="radio"/> Right
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l) **If** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)

m) **If** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD      OS	Without corrective lenses OD      OS	Date of last exam (dd/mmm/yyyy)
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n) **If** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

**4 Treatment**

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

<input type="radio"/> Recovered <input type="radio"/> Improved <input type="radio"/> No change <input type="radio"/> Retrogressed	Comments
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f) Is your patient following the recommended treatment program?

Yes    No   ***If no, please elaborate:***

g) Details of any **proposed** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

**5 Competency**

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

Yes  No **If no, from what date?**

Date (dd/mmm/yyyy)

**6 Licence restriction**

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

Yes  No

Restricted  Suspended  Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

**If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?**

Date (dd/mmm/yyyy)

**7 Remarks**

**Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.**

Name of attending physician (please print)

Specialty

Telephone (include area code)

Fax (include area code)

( )

( )

Address (number, street and apartment)

City

Province

Postal code

Signature

Date signed (dd/mmm/yyyy)

The information in this statement will be kept in a group life, health, or disability benefits file with 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 you consent to such unedited release of any information contained herein.