

# Initial Disability Insurance Medical Statement

The patient is responsible for any fees related to the completion of this form.

<b>Section 1</b>	<b>Patient Information and Consent TO BE COMPLETED BY THE PATIENT</b>																				
Patient Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)																		
Address (Street, City, Province, Postal Code)																					
Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd-mm-yyyy)																		
Date Last Worked (dd/mm/yyyy)		Date Returned to Work or Expected Return to Work Date (dd-mm-yyyy)																			
Please list your present medications: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Name of Medication</th> <th style="width: 20%;">Dosage (mg)</th> <th style="width: 20%;">How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Please provide your:  Height: _____ Weight: _____  Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?																			
1. _____	_____	_____																			
2. _____	_____	_____																			
3. _____	_____	_____																			
4. _____	_____	_____																			
5. _____	_____	_____																			
I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. 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. <b>Medical and health information excludes genetic test results.</b>																					
Patient Signature _____		Date of Consent (dd/mm/yyyy) _____																			
<b>Section 2</b>	<b>Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)</b>																				
I am the: Family Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____																					
<b>PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE</b>																					
<b>Diagnosis</b>																					
Primary: _____																					
Secondary and/or Complications: _____																					
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>																					

Is this condition due to:

Occupational Illness    Yes     No

Occupational Injury    Yes     No

Motor vehicle accident    Yes     No

Other accident    Yes     No

If yes, date of event: (dd/mm/yyyy) \_\_\_\_\_

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Have you completed any other disability claim forms recently for this patient?    Yes     No

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) \_\_\_\_\_

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

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Frequency of Visits:    Weekly     Monthly     Other  (describe) \_\_\_\_\_

Date of last visit: (dd/mm/yyyy) \_\_\_\_\_

Date of next visit: (dd-mm-yyyy) \_\_\_\_\_

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Has the patient been treated for this same or similar condition in the past?    Yes     No     Unknown

If yes, date: (dd/mm/yyyy) \_\_\_\_\_    Treatment Provider: \_\_\_\_\_

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Is the patient following the recommended treatment program?    Yes     No

Please elaborate: \_\_\_\_\_

\_\_\_\_\_

**Response to Treatment**

Please describe the response to treatment to date:    Complete     Partial     None     Too soon to tell

Are there any plans to change or augment the current treatment program?    Yes     No

If so, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Hospitalization</b>		
Is/was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is future hospitalization planned? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did/will the patient have day surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):		
Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
If surgery was/will be performed, please provide date(s) and description of surgery(s):		
Date (dd/mm/yyyy)	Description	
1. _____	_____	
2. _____	_____	
	<ul style="list-style-type: none"> <li>If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.</li> <li>For disabilities expected to be greater than 4 weeks, please complete all pages.</li> </ul>	
<b>Investigations</b>		
Please attach copies of all relevant:		
	<ul style="list-style-type: none"> <li>test results/investigations (If test results are not attached, we will interpret this as tests were not performed) – <u>do not provide genetic test results</u></li> <li>consultation reports</li> <li>clinical notes</li> </ul>	
Are tests/investigations pending? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date (dd/mm/yyyy)	Description	
1. _____	_____	
2. _____	_____	
If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Specialist	Specialty	Date (dd/mm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

**Clinical Findings and Observations**

Please describe the patient's symptoms including history, severity and frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How have the patient's symptoms evolved to date? Improved  No Change  Retrogressed

**Restrictions and Limitations**

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

Has any license held by the patient been restricted or revoked as a result of this condition? Yes  No

If yes, as of when? (dd/mm/yyyy) \_\_\_\_\_ Type of license: \_\_\_\_\_

Is the patient capable of managing their own affairs? Yes  No

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes  No

Workplace Issues  Social/Family Issues  Financial/Legal Issues  Personality issues  Addiction  Other

Please elaborate: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prognosis**

Please provide the patient's prognosis for improvement and/or recovery:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Return-to-Work**

What return-to-work goals have been discussed with the patient? Please elaborate:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Notice to Physician/Medical Provider:**

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)		Specialty and license/registration number	Date Signed (dd-mm-yyyy)
Address (Street, City, Province, Postal Code)		Telephone # (+ area Code)	Fax Phone # (+ area Code)
			Email address
Signature			

**Return address**

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. It can also be emailed to [disabilityclaims@sunlife.com](mailto:disabilityclaims@sunlife.com). If you choose to send your information by email, we can't guarantee the privacy or security of the email communications while they are on their way to Sun Life. Please retain the original copy for your records.

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|--|--|---|---|
| <p><b>Halifax:</b><br/> <b>Fax: 1-866-639-7850</b><br/>         PO Box 11480 Stn CV<br/>         Montreal QC H3C 5P5</p>   | <p><b>Montreal:</b><br/> <b>Fax: 1-866-639-7846</b><br/>         PO Box 11037 Stn CV<br/>         Montreal QC H3C 4W8</p>        | <p><b>Toronto:</b><br/> <b>Fax: 1-866-639-7851</b><br/>         PO Box 950 Stn A<br/>         Toronto ON M5W 1G5</p>  | <p><b>Kitchener - Waterloo:</b><br/> <b>Fax: 1-866-209-7215</b><br/>         PO Box 100 Stn C<br/>         Kitchener ON N2G 3W9</p> |
| <p><b>Edmonton:</b><br/> <b>Fax: 1-866-639-7820</b><br/>         PO Box 2733 Stn Main<br/>         Edmonton AB T5J 5C9</p> | <p><b>Vancouver:</b><br/> <b>Fax: 1-866-639-7829</b><br/>         PO Box 48810 Stn Bentall<br/>         Vancouver BC V7X 1A6</p> | <p><b>Montreal<br/>         Federal Government<br/>         Disability Insurance Plan</b><br/> <b>Fax: 1-866-639-7849</b><br/>         PO Box 12500 Stn CV<br/>         Montreal QC H3C 5T6</p> |   |