

Extension of Disability
Claimant's Statement

Part A

First name : _____ Last name : _____
 Policy number : _____ Telephone number : _____
 Address : _____

1. Since the last medical report :

- a) How many medical consultations have you had? _____
- b) Name all physicians consulted : _____
- c) Have you been hospitalized? Yes No
 If yes, where and when? _____

2. Are you presently performing any type of work, even part-time, for which you receive any form of remuneration? Yes No

If yes, since when? _____
 Nature of work: _____

3. Do you expect to return to work Yes No

If yes, when? _____

4. Describe any limitations or restrictions which prevent you from working: _____

5. Describe your present symptoms and the changes in your condition since your last report: _____

6. Have you applied for, are you receiving or are you eligible to receive any disability benefits under the following plans?

Group Disability Plan Yes No Give Details: _____

Canada/Quebec Pension Plan Yes No Give Details: _____

Other Plans Yes No Give Details: _____

Declaration and authorization

I hereby certify that the information given above is true and authorize the release of any information in respect of this claim to the insurer and authorized representatives.

A copy of this authorization shall be as valid as the original.

_____ Date

_____ Signature of Claimant

Part B must be completed by our treating physician.

Extension of Disability Physician's Statement

Part B

First name : _____ Last name : _____ Date of birth : _____

**The patient is responsible for securing this form and for any charges for its completion.
This form may be mailed directly to the Insurer or given to the patient at the physician's discretion.**

1. Diagnosis

- a) Primary : _____
b) Secondary (if applicable) : _____

2. Present condition (Please include results of current X-rays, E.K.G. or any other special tests and copies of consultation reports)

- a) Describe complications, recent surgery or new independent condition(s) which are contributing to the duration of disability: _____
b) Has patient : recovered improved not improved retrogressed
c) Patient is : ambulatory bed confined house confined hospital confined
d) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? Yes No

3. Cardiac (if applicable) :

- a) Functional Capacity : Class 1 (no limitation) Class 2 (slight limitation)
 Class 3 (marked limitation) Class 4 (complete limitation)
b) Blood Pressure (latest visit) : _____ / _____
Systolic/diastolic

4. Current treatment :

- a) If drugs prescribed, names and dosages : _____
b) Other treatment : give details _____

5. Extent of disability

- a) Is patient now totally disabled for regular occupation ? Yes No Other occupation? Yes No
b) If "No", when was patient able to resume work for regular occupation? _____ Other occupation? _____
c) If "Yes", when should patient be able to resume work for regular occupation? _____ Other occupation? _____
d) If indefinite, the estimated number of additional weeks/months before patient's return. _____

6. Physical limitations

- Yes No
If "Yes", what are the limitations? _____
Are these limitations : temporary, duration _____ permanent?

7. Notes

Declaration and authorization

I hereby certify that, to the best of my knowledge, the answers given above are full and true.

Physician's name : _____ Telephone number: _____

Address: _____ Fax number: _____

Physician's signature: _____ Date: _____