Assumption Life

Reset

Attending Physician's Statement
Long-Term Disability

Part 1: Assignment, Certification & Authorization

First name: _____ Last name: _____

Policy number: _____ Date of birth (DD/MM/YYYY): _____

Name of employer: _____

Authorization:
I certify that the information in this form is true and complete and authorize the release of this information to the insurance company and their representatives. I understand that the claims analyst may investigate this claim. I authorize my employer, physician, practitioner, healthcare professional, hospital, healthcare institution, medical organization, clinic and other medically-related facility, insurance company, Workers' Compensation authority, Canada or Quebec Pension Plan and group plan administrator to release to and exchange with the claims analyst any medical or benefit payment information to process or manage my claim.

I agree that a photocopy of this authorization shall be as valid as the original.
I understand that I am responsible for any charges related to the completion of forms or medical reports.

Claimant's signature: _____ Date (DD/MM/YYYY): _____

Part 2: Attending Physician's Statement

PLEASE ANSWER EACH QUESTION AND PROVIDE COPIES OF RELEVANT TEST RESULTS.

1. History of Illness or injury

a) When did symptoms first appear or accident happen? (DD/MM/YYYY) _____/_____/_____

b) Date patient ceased work because of disability. (DD/MM/YYYY) _____/_____/_____

c) Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: (history, severity, frequency, etc.)

_____
_____
_____

d) Is this condition due to an occupational illness/injury? ☐ Yes ☐ No If yes, date of event (DD/MM/YYY): _____/_____/_____

e) Is the disability related to pregnancy? ☐ Yes ☐ No Expected date of delivery (DD/MM/YYYY): _____/_____/_____
Preventative leave? ☐ Yes ☐ No

2. Diagnosis

a) Primary_____
_____
_____

b) Secondary and/or complications:_____
_____
_____
_____

c) Subjective symptoms and general observations:
_____
_____
_____

d) Procedures and examinations (please include copies of results):
_____
_____
_____
_____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

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3. Treatment

a) First visit: _____/_____/_____ Last visit : _____/_____/_____ Next visit: _____/_____/_____
DD MM YYYY DD MM YYYY DD MM YYYY

b) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

c) Medications (indicate dosage and date prescribed):
_____
_____
_____

d) Hospital admission - Name of hospital:_____ Date (DD/MM/YYYY): _____/_____/_____

e) Surgery - Type: _____ Date (DD/MM/YYYY): _____/_____/_____

f) Consulting Physician(s) - Name: _____ Specialty:_____

g) Other specialist(s) - Name: _____ Specialty:_____

h) Please provide details of other treatments administered:_____
_____
_____
_____

i) Are tests/investigations pending? ☐ Yes ☐ No If yes, please indicate date and description: _____
_____
_____
_____

j) Please describe response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

4. Cardiac condition (if related to disability) (Functional capacity according to the American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation) Blood pressure at last visit: _____/_____

5. Restrictions and limitations

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

6. Return to work

a) Estimated date of return to regular work (DD/MM/YYYY): _____/_____/_____

b) Date on which the patient is able to return to modified duties or other type of work (DD/MM/YYYY): _____/_____/_____

c) General comments:
_____
_____
_____
_____

_____ _____
Attending physician's name (in block letters) Address

_____ _____ _____ _____
Telephone number Physician's signature Specialty Date (DD/MM/YYYY)

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