## Proof of Total Disability - Physician's Statement

**Please complete in block letters and give to the patient. The insured must pay the fees requested to complete this form.**

### A - STATEMENT

| Employee Name | Policy Number |
|---|---|
| Telephone Number | Date of Birth (YYYY/MM/DD) |

Mental Condition
Is the patient competent to endorse cheque and direct the use of the proceeds thereof?

### B - DIAGNOSIS

Primary

Secondary

Complications

For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments    ☐ consulted another physician    ☐ taken drugs    ☐ been hospitalized    ☐ undergone examinations

Specify the periods: _____

Is the disability related to:

☐ an accident    ☐ an illness    ☐ an occupational accident    ☐ an automobile accident

Date of the event (YYYY/MM/DD) _____

Describe the functional limitations that prevent the patient from carrying out professional duties or usual activities

At the beginning of the disability (YYYY/MM/DD): _____

Currently:

### C - TREATMENT

Drugs - name - dosage: _____

Has the patient undergone or will undergo:
a) examinations or tests    ☐Yes  ☐No    Specify: _____
b) surgery    ☐Yes  ☐No    Day Surgery ☐    Type: _____
    Surgical procedure: _____    Date (YYYY/MM/DD): _____
c) other treatments    ☐Yes  ☐No
d) hospitalization: From _____ To _____ Name of hospital: _____
e) a short stay under observation  ☐Yes  ☐No    Number of hours: _____

## D - FOLLOW-UP AND PROGNOSIS

Date of first consultation for this disability (YYYY/MM/DD): _____ Next consultation: _____

Date of other consultations (YYYY/MM/DD): _____ Follow-up frequency: _____

Referral to another physician: ☐Yes ☐No    Name of Physician: _____

Specialty: _____

Approximate duration of disability: No. of days: _____ No. of weeks: _____ Unspecified☐    or date of return to work (YYYY/MM/DD): _____

How long before the patient will be able to return to work: No. of days: _____ No. of weeks: _____

☐Part-time  ☐Full-time  ☐Gradual return    Specify: _____

## E - ADDITIONAL INFORMATION

## F - IDENTIFICATION OF THE PHYSICIAN

Family name, given name: _____

License number: _____    Telephone: _____  Fax: _____

☐General Practitioner  ☐Specialist    Specify: _____

Signature                                          Date (YYYY/MM/DD)