Manulife

Group Benefits
Attending Physician's Statement - Short Term Group Disability Claim

The purpose of this Statement is to assist Manulife Financial in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife Financial to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. ***PLEASE KEEP A COPY FOR YOUR RECORDS****.*

Return completed form to: **Prairie Teamsters Administration Services**
155 - 7260 12 ST SE
CALGARY AB T2H 2S5
Tel: (403) 252-6924
Fax: (403) 253-3231

OR Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 4217 STN C
CALGARY AB T2T 5N1
Telephone: 1-877-481-9169 Fax: 1-866-635-3050

1 Patient authorization

Name of patient (last, first, middle initial)	Plan contract number	Division number

Address

Date of birth (dd/mmm/yyyy)	Height	Weight	Social Insurance Number

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. **I understand that I am responsible for any fees related to the completion of this form.**

Patient's signature	Date (dd/mmm/yyyy)

2 Attending physician's statement

A. History

When did symptoms first appear or accident happen? Date (dd/mmm/yyyy)

What date did patient cease work because of illness/injury? Date (dd/mmm/yyyy)

Has patient ever had the same or a similar condition? ◯ Yes ◯ No

If *yes*, state when and describe.

Is condition due to injury or sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown

Is a claim being submitted to any type of worker's compensation board? ◯ Yes ◯ No

Has the patient been confined in a hospital?
If available please include admission and discharge summaries. ◯ Yes ◯ No

If *yes*

Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)

Name, specialty and address of other treating physician(s)

Name	Specialty	Address

B. Diagnosis

a) Primary

b) List any additional conditions or complications

c) Subjective symptoms

d) **Please include copies of the following documentation in support of the stated diagnosis: consultation notes, test/investigation report(s), psychological testing report(s), operative report(s), hospital admission and discharge summary(ies).**

If your patient is/was pregnant, please provide the expected/actual delivery date. (dd/mmm/yyyy)

3 Treatment

Frequency of visits

- Weekly
- Monthly
- Other (specify)

Date of first visit (dd/mmm/yyyy)

Date of last visit (dd/mmm/yyyy)

Date of all visits between first and last visit (dd/mmm/yyyy)

Nature of treatment (including surgery, physiotherapy, psychotherapy and medications prescribed and dosages)

When do you expect a significant change in the functional limitation affecting your patient?

To your knowledge is patient following the recommended treatment program? ◯ Yes ◯ No

Is there potential for future improvement? ◯ Yes ◯ No

If *no*, please comment.

Have you recommended that your patient's driver's licence be revoked? ◯ Yes ◯ No

4 Physical impairment

Does your patient have a physical impairment?

◯ Yes ◯ No

If *yes*, please complete this section.

Based on objective findings please describe your patient's abilities in the following areas:

lifting	(max. weight/frequency)	sitting	(how long/frequency)
carrying	(max. weight/distance)	standing	(how long/frequency)
		walking	(distance/frequency)

Remarks

5 Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

◯ Yes ◯ No

If *yes*, please complete this section.

Indicate if patient has cognitive/mental restrictions in the following areas.

	None	Mild	Moderate	Severe
◯ concentration				
◯ analytical reasoning				
◯ learning new material				
◯ comprehension				
◯ social interaction				

What is the DSM IV diagnosis? (Axis 1)

What is the current GAF?

Remarks

Please provide copies of consultation reports and your most recent mental status test results and list all abnormal findings supporting the above restrictions.

Competency

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ◯ Yes ◯ No

6 Cardiac (if applicable)

a) Functional capacity (American Heart Association)

- ◯ Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.
- ◯ Class 2 - Greater than ordinary physical activity results in symptoms.
- ◯ Class 3 - Ordinary physical activity results in symptoms.
- ◯ Class 4 - Symptoms at rest, and worse with any physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

7 Physician's authorization

PRINT

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.

Attending physician (please print)

Certified specialist

Telephone number (include area code)

Address (number, street, suite, city, province, postal code)

Fax number (include area code)

Signature

Date signed (dd/mmm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM, IN THE PROVINCES WHERE APPLICABLE.