Attending Physician's Statement - Short Term Disability Claim

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

Plan Member/Employee Information and Consent: To Be Completed By The Patient

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)		
Employer's Name	Plan Contract #	Member Certificate #
Height / Weight	Date of Birth (dd/mm/yyyy) _____	
Last Date Worked (dd/mm/yyyy) _____	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy) _____	

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. 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 may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. Medical and health information excludes genetic test results.

_____ _____

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

Questions To Be Completed By the Physician (or Nurse Practitioner Where Applicable)

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: _____

_____

_____

Secondary and/or Complications: _____

_____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐	Auto accident Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy) _____	If yes, date of event: (dd/mm/yyyy) _____
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy) _____ Date of discharge (dd/mm/yyyy) _____ Institution Name _____

If surgery was performed please provide date and description of surgery

Date (dd/mm/yyyy) _____ Description: _____

Treatment (drug, dosage, physiotherapy, other):

_____

_____

Prognosis Please provide the prognosis for recovery:

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

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

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

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

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other_____

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results.**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty_____ Date of Visit _____

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

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program? Yes ☐ No ☐

Do you have concerns about the patient's ability to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

Notice to Physician

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 (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code) Fax # (+ area code)
Signature or Stamp		

Mail: Co-operators Life Insurance Company, Disability Claims Department, 1900 Albert Street Regina SK S4P 4K8 Fax: 1-866-889-9926