THE Great-West Life ASSURANCE COMPANY

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

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Other Conditions

Attending Physician's Statement - Long Term Disability Claim

Section 1	Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)			
Employer's Name	**Group Plan Number**	**GWL Employee Identification Number**	**Date of Birth** (dd/mm/yyyy)
Date Last Worked (dd/mm/yyyy)		**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy)	

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1.		
2.		
3.		
4.		
5.		

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

_____ _____

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

Section 2	Attending Physician's Statement TO BE COMPLETED BY THE DOCTOR

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

_____

Secondary and/or Complications: _____

_____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____

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Is this condition due to:

Occupational Illness/injury Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Auto Accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition:

(dd/mm/yyyy) _____

First date of work absence due to condition:

(dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

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

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

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

Please elaborate: _____

Response to Treatment

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

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

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Investigations

Please attach copies of all relevant:
- **test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

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

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Functional Abilities

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities:

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Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐ Please elaborate:

_____

_____

_____

_____

_____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

_____

_____

_____

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

_____

_____

_____

_____

_____

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. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	