CLHIA ACCAP

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

THE Great-West Life ASSURANCE COMPANY

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

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

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 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)

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

STOP

- **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:

_____

_____

CLHIA ACCAP

THE Great-West Life ASSURANCE COMPANY

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)**
- **consultation reports**

If consultation report is not attached, please indicate if the 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 functional abilities.

_____

_____

_____

_____

_____

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 ☐

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. 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)	

M5454-8/18