Assumption Life

Attending Physician's Statement
Long-Term Disability

Part 1: Assignment, Certification & Authorization

First name: ______________________ Last name: ______________________

Policy number: ______________________ Date of birth (DD/MM/YYYY): ______________________

Name of employer: ______________________

Authorization:
I certify that the information in this form is true and complete and authorize the release of this information to the insurance company and their representatives. I understand that the claims analyst may investigate this claim. I authorize my employer, physician, practitioner, healthcare professional, hospital, healthcare institution, medical organization, clinic and other medically-related facility, insurance company, Workers' Compensation authority, Canada or Quebec Pension Plan and group plan administrator to release to and exchange with the claims analyst any medical or benefit payment information to process or manage my claim.

I agree that a photocopy of this authorization shall be as valid as the original.
I understand that I am responsible for any charges related to the completion of forms or medical reports.

Claimant's signature: ______________________ Date (DD/MM/YYYY): ______________________

Part 2: Attending Physician's Statement

PLEASE ANSWER EACH QUESTION AND PROVIDE COPIES OF RELEVANT TEST RESULTS.

1. History of Illness or injury

a) When did symptoms first appear or accident happen? (DD/MM/YYYY) ________/________/_________

b) Date patient ceased work because of disability. (DD/MM/YYYY) ________/________/_________

c) Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: (history, severity, frequency, etc.)

____

____

____

d) Is this condition due to an occupational illness/injury? ☐ Yes ☐ No If yes, date of event (DD/MM/YYY): ______/_______/_______

e) Is the disability related to pregnancy? ☐ Yes ☐ No Expected date of delivery (DD/MM/YYYY): ______/_______/_______

Preventative leave? ☐ Yes ☐ No

2. Diagnosis

a) Primary____

____

____

b) Secondary and/or complications:____

____

____

____

c) Subjective symptoms and general observations:

____

____

____

d) Procedures and examinations (please include copies of results):

____

____

____

____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,

P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

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3. Treatment

a) First visit: ______/_______/_________ Last visit : ______/_______/________ Next visit: ______/______/________
DD MM YYYY DD MM YYYY DD MM YYYY

b) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): ____

c) Medications (indicate dosage and date prescribed):
____
____
____

d) Hospital admission - Name of hospital:_____________________________________ Date (DD/MM/YYYY): ______/______/_______
e) Surgery - Type: ____ Date (DD/MM/YYYY): ______/______/_______
f) Consulting Physician(s) - Name: ____ Specialty:____________________________
g) Other specialist(s) - Name: ____ Specialty:____________________________
h) Please provide details of other treatments administered:____
____
____
____

i) Are tests/investigations pending? ☐ Yes ☐ No If yes, please indicate date and description: ___________________________
____
____
____

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

4. Cardiac condition (if related to disability) (Functional capacity according to the American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation) Blood pressure at last visit: _______/________

5. Restrictions and limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and physical restrictions and limitations:
____
____
____
____

6. Return to work
a) Estimated date of return to regular work (DD/MM/YYYY): ______/______/_______
b) Date on which the patient is able to return to modified duties or other type of work (DD/MM/YYYY): ______/______/_______
c) General comments:
____
____
____
____

____ ______________________________________
Attending physician's name (in block letters) Address

____________________ __________________________ ____________________ ____________
Telephone number Physician's signature Specialty Date (DD/MM/YYYY)

4226-00A-JUL14

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