UV INSURANCE

INDIVIDUAL INSURANCE

# Disability Insurance Claim - Attending Physician's Statement

EQC027

**Important:** Please print and complete each section as accurately as possible.

## Section A – Collection, Use and Disclosure of Personal Information

This form allows UV Insurance to process a claim for disability insurance benefits by collecting information from the attending physician.

The personal information is used to:

- Identify the individual
- Initiate or continue a claims process
- Comply with legal and regulatory requirements (in particular to prevent, detect or prosecute offences, cyber threats and fraud)

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the application, as well as to any other person authorized by law.

## Section B – Patient Identification

1. Contract # _____
2. First name _____ Last name _____
3. Occupation _____
4. Date of birth Y M D

## Section C – Diagnosis

**Note:** If the condition is psychiatric in nature, please specify the code and axis according to the DSM IV.

1. Primary (including all complications)

2. Secondary (or other conditions that may affect the duration of the disability)

3. Subjective symptoms

4. Objective symptoms (recent results of X-rays, ECGs, laboratory tests and other tests)

## Section D – History of the Illness

1. Date of onset of symptoms or date of accident Y M D
2. Date of work stoppage date due to this disability Y M D
3. Has the patient previously suffered from this condition or a similar one? ☐ Yes ☐ No ☐ I don't know
   If **Yes**, enter the date and provide details Y M D
   _____
4. Is this a chronic condition? ☐ Yes ☐ No Is it a recurrent condition? ☐ Yes ☐ No
   If **Yes**, what is the cause of the current work stoppage? _____
5. If the patient has had this condition for a long time, has their health:
   ☐ Remained the same ☐ Improved ☐ Slightly worsened ☐ Considerably worsened
6. Is the condition attributable to an accident or an occupational disease? ☐ Yes ☐ No ☐ I don't know
7. Is this condition directly or indirectly related to a pregnancy? ☐ Yes ☐ No
   If **Yes**, enter the expected date of delivery Y M D
8. Names and specialties of other attending or consulting physicians or therapists
   (If applicable, specify in **Section I – Remarks**)

## Section E – Treatment

1. Date of first consultation Y M D
2. Date of last consultation Y M D
3. Frequency of consultations ☐ Weekly ☐ Monthly ☐ Other frequency Please specify _____
4. Type of treatment and expected duration

   | |
   |---|
   | |

5. Names of prescribed medications and current dosage

   | |
   |---|
   | |

6. Has the patient undergone surgery? ☐ Yes ☐ No ☐ Pending Date Y M D
   Nature of the procedure _____
7. Is the patient currently hospitalized or have they been hospitalized? ☐ Yes ☐ No
   If **Yes**, provide dates and the name of hospital or rehabilitation centre From Y M D to Y M D
   Location _____
8. Is the patient following the recommended treatments? ☐ Yes ☐ No If **No**, provide details in **Section I – Remarks**.

## Section F – Current Health Status

### Cardiac condition (if the disability is related)

1. Functional capacity ☐ No restrictions ☐ Mild restrictions ☐ Significant restrictions ☐ Full restrictions
2. Blood pressure at the last visit Systolic _____ Diastolic _____

### Physical condition

1. ☐ No restrictions; able to engage in any physical activity
2. ☐ Mild restriction; light manual labour that does not require repetitive movements
3. ☐ Moderate restriction; normal work requiring moderate effort with the possibility of repetitive movements
4. ☐ Significant restriction; work requiring sustained effort
5. ☐ Full restriction; no form of work, even sedentary

For restrictions **3, 4 and 5**, please check the activities that **cannot** be performed because of the patient's health status

| | | |
|---|---|---|
| ☐ Running | ☐ Lifting a load exceeding _____ lb/kg | ☐ Maintaining balance |
| ☐ Climbing | ☐ Carrying a load exceeding _____ lb/kg | ☐ Driving a motor vehicle |
| ☐ Bending | ☐ Kneeling | ☐ Operating heavy machinery |

### Psychological condition

1. ☐ The patient can adapt to stressful situations and function in society
2. ☐ The patient can adapt to some stressful situations and function in society in certain cases
3. ☐ The patient can adapt to some stressful situations and function in society in almost all cases
4. ☐ The patient is unable to adapt to stressful situations or function in society
5. ☐ The patient has difficulty coping with psychological, physiological, personal and social challenges

## Section G – Prognosis

1. Is the patient completely unable to perform their regular occupation? ☐ Yes ☐ No Since when? Y M D
   If **yes**, when will they be able to resume it? Date Y M D ☐ Never
   If **No**, on what date could they resume it? Date Y M D
   If a date cannot be determined, provide the estimated number of additional weeks needed to achieve a sufficient level of recovery to attempt a return to work _____ weeks
2. Is the patient completely unable to perform any other gainful occupation? ☐ Yes ☐ No

## Section H – Functional Rehabilitation

1. Would career counselling or retraining be appropriate? ☐ Yes ☐ No
2. Could the patient's condition require a gradual return to work? ☐ Yes ☐ No
3. Is the patient's condition sufficiently stable such that a short-term, gradual return to part-time work would be appropriate and beneficial? ☐ Yes ☐ No
   If **Yes**, please provide your recommendations in **Section I – Remarks**, and be sure to specify why a return to full-time work is not possible.

## Section I – Remarks

## Section J – Consent and Signature

Note that if any of the personal information provided herein is inaccurate, incomplete or ambiguous, the insured may request a correction by submitting a request to UV Insurance.

For more details, please visit our website and see our **Privacy Policy**.

### Physician's signature

As the attending physician, I declare that I am acting in accordance with privacy laws and regulations. By signing at the bottom of this form, I confirm that the information provided is accurate.

1. Physician's name _____
2. Specialty _____
3. Address _____

   City _____ Province _____ Country _____ Postal code _____
4. Telephone ___ ___ - ___

**X** _____ Date Y M D

Physician's signature

### Patient's signature

By signing below, the patient confirms that they have read and agree to the information in this form.

**X** _____ _____ Date Y M D

Patient's signature Name of patient (please print)



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