

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

## Initial Disability Insurance Medical Statement

| <b>Section 1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Patient Information and Consent<br/>TO BE COMPLETED BY THE PATIENT</b>                   |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------|-------------|------------|----------|-------|-------|----------|-------|-------|----------|-------|-------|----------|-------|-------|----------|-------|-------|------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name (Last, First, Middle Initial)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             | Home Phone # (+ Area Code)                                                  | Cell Phone # (+ Area Code)    |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Address (Street, City, Province, Postal Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Employer's Name (if applicable)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | Contract or Policy #                                                        | Certificate # (if applicable) |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Date of Birth (dd/mm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Date Last Worked<br>(dd/mm/yyyy) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             | Date Returned to Work or Expected Return to Work Date<br>(dd/mm/yyyy) _____ |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Please list your present medications:<br><table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name of Medication</th> <th style="width: 20%;">Dosage (mg)</th> <th style="width: 20%;">How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>                                                                                                |                                                                                             |                                                                             | Name of Medication            | Dosage (mg) | How Often? | 1. _____ | _____ | _____ | 2. _____ | _____ | _____ | 3. _____ | _____ | _____ | 4. _____ | _____ | _____ | 5. _____ | _____ | _____ | Please provide your:<br>Height: _____<br>Weight: _____<br>Dominant Hand:<br>Left <input type="checkbox"/> Right <input type="checkbox"/> |
| Name of Medication                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Dosage (mg)                                                                                 | How Often?                                                                  |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| 1. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _____                                                                                       | _____                                                                       |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| 2. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _____                                                                                       | _____                                                                       |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| 3. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _____                                                                                       | _____                                                                       |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| 4. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _____                                                                                       | _____                                                                       |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| 5. _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _____                                                                                       | _____                                                                       |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| I hereby authorize the release of medical and health information in my file to _____<br>(Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. 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 cannot be assessed.<br>I understand that I am responsible for any fees related to the completion of this form. <b>Medical and health information excludes genetic test results.</b> |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Patient Signature _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             | Date of Consent (dd/mm/yyyy) _____                                          |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| <b>Section 2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Medical Statement<br/>TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)</b> |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| I am the:    Family Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| <b>PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| <b>Diagnosis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Primary: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| Secondary and/or Complications: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |
| If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____    Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                             |                               |             |            |          |       |       |          |       |       |          |       |       |          |       |       |          |       |       |                                                                                                                                          |



Is this condition due to:

Occupational Illness      Yes ☐    No ☐  
 Occupational Injury      Yes ☐    No ☐  
 Motor vehicle accident    Yes ☐    No ☐  
 Other 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**)

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Frequency of Visits:    Weekly ☐    Monthly ☐    Other ☐ (describe) \_\_\_\_\_

Date of last visit: (dd/mm/yyyy) \_\_\_\_\_

Date of next visit: (dd/mm/yyyy) \_\_\_\_\_

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

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 ☐

Did/will the patient have day surgery?    Yes ☐    No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

| 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. \_\_\_\_\_



- If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.
- For disabilities expected to be greater than 4 weeks, please complete all pages.

### 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) - do not provide genetic test results
- consultation reports
- clinical notes

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 ☐



## Restrictions and Limitations

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

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Has any license 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 license: \_\_\_\_\_

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: \_\_\_\_\_

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## Prognosis

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

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## Return-to-Work

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

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## Notice to Physician/Medical Provider:

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/Medical Provider  
(please print)

Specialty and license/registration number

Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)

Telephone # (+ area code)

Fax # (+ area code)

Email address

Signature

Through this form, UV Insurance collects your personal information in order to process your disability benefit claim and for the administration of the insurance plan or contract.

Your personal information may also be used specifically to:

- ▶ Confirm your identity;
- ▶ Establish and update the profile, needs, and objectives;
- ▶ Comply with legal and regulatory requirements (e.g., to prevent, detect or suppress offences, cyber threats, and fraud).

The information disclosed in this form will be shared with UV Insurance personnel responsible for processing your request, as well as with any other person authorized by law.

If any of your personal information is inaccurate, incomplete, or unclear, you may request a correction by getting in touch with UV Insurance.

You also have the right, upon request, to be informed about how your personal information is used.

You may withdraw your consent to the disclosure or use of your personal information at any time by sending a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud street, Drummondville (Quebec) J2C 7G7.

For more information, please visit our website to view our Privacy Policy. <https://www.uvassurance.ca/en/privacy-policy>