UV INSURANCE

INDIVIDUAL INSURANCE

Attending Physician's Statement

Assessment of Loss of Independent Existence

FQC096

Important: Fill out in block letters and answer each section as accurately as possible

Section A – Disclosure of Personal Information

This form allows UV Insurance to collect the insured person's personal information through their attending physician in order to obtain information about their loss of independent existence. This information is collected by accessing information about their health status and medical history.

The personal information collected is used to:

- Identify the insured person
- Properly assess their state of health
- 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 request, as well as to any other person authorized by law.

Section B – Patient Identification (to be completed by the insured person)

1. Contract # _____
2. First name _____ Last name _____
3. Date of birth |__|__|__|__|__|__|__|__| 4. Social Insurance Number |__|__|__|__|__|__|__|__|__|

Section C – Assessment of Loss of Independent Existence (to be completed by the attending physician)

Diagnosis

1. Primary _____ Date of onset of symptoms |__|__|__|__|__|__|__|__|
2. Secondary _____ Date of onset of symptoms |__|__|__|__|__|__|__|__|
3. Diagnostic tests performed **(Please attach a copy of the assessment report)**
   a) _____ b) _____ c) _____
4. Current symptoms _____
5. Severity of all symptoms? ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements
6. Causes that led to the diagnosis?
   ☐ Accident ☐ Illness ☐ Alcohol or drug abuse ☐ If other, please specify: _____
7. Date of your patient's first consultation? |__|__|__|__|__|__|__|__|
8. What was the main reason for the consultation? _____
9. Date of your patient's last consultation? |__|__|__|__|__|__|__|__|
10. What was the main reason for the consultation? _____
11. What are the current treatments? _____
12. Is your patient following the treatments recommended by the various healthcare professionals? ☐ Yes ☐ No
    If **No**, please specify: _____

Section D – Activities of Daily Living (ADL) (to be completed by the attending physician)

Need for assistance (please refer to the ADL definitions below to complete the assessment)

Washing oneself
means washing, with or without the aid of assistive devices, in a bathtub or shower, including getting into and out of the bathtub or shower, or washing oneself with a washcloth. Washing oneself does not include the ability to reach and wash one's back or feet.

Dressing
means putting on, taking off, fastening and unfastening, with or without the aid of assistive devices, clothing and medically necessary orthopedic devices or prosthetic limbs. The insured is not functionally dependent for dressing if reasonable alterations or modifications to the clothing they normally wear would enable them to dress without requiring significant physical assistance.

Using the toilet
means going to and from the toilet, sitting on the toilet seat, standing up, with or without the aid of assistive devices, and performing related personal hygiene activities.

Moving around
means lying down, getting out of bed, sitting down, getting up from a chair or wheelchair, with or without the aid of assistive devices.

Eating
means consuming food or beverages that have been prepared and served, with or without the aid of functional utensils.

Remaining continent
means the ability to control bladder (urination) or bowel (defecation) function or to maintain a reasonable level of personal hygiene (including the care required for a catheter or colostomy bag) if the insured is unable to control either function.

1. Please indicate the level of assistance your patient requires to perform activities of daily living by checking only one box per activity.

Activities of Daily Living (ADL)	No assistance	Requires some assistance or partial supervision	Needs direct assistance	Permanent disability
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Personal hygiene	☐	☐	☐	☐
Remaining continent	☐	☐	☐	☐
Moving around	☐	☐	☐	☐
Eating	☐	☐	☐	☐

2. When did your patient first require partial or full assistance to perform an activity?

   Date |__|__|__|__|__|__|__|__|

3. Please provide any other relevant information to help us understand your patient's daily assistance needs.

Note: If applicable, please attach any occupational therapy assessment reports.

Section E – Cognitive Impairment (to be completed by the attending physician)

Cognitive impairment must have an organic basis, as defined below.

Deterioration of mental faculties (cognitive disorder or impairment) means that constant supervision by another person is required to protect physical health and safety due to the deterioration or loss of:

- short-term memory;
- orientation in time and space and the ability to recognize people;
- the ability to reason; and
- the ability to make judgments regarding awareness of danger.

The deterioration of mental faculties must be caused by an organic brain disease, such as Alzheimer's disease or irreversible dementia, or by head trauma.

1. Has your patient been diagnosed with cognitive impairment with an organic basis? ☐ Yes ☐ No

   If **Yes**, please specify _____

   Date of onset of cognitive impairment |__|__|__|__|__|__|__|__|

2. Diagnostic tests performed **(Please attach a copy of the assessment report)**

   a) _____ b) _____ c) _____

3. What is the degree of cognitive impairment in your patient?

   ☐ None ☐ Mild ☐ Severe; my patient requires daily assistance

4. Please provide any other relevant information related to your patient's ability to perform their daily activities.

Section F – Identification of the Attending Physician (to be completed by the attending physician)

1. First name _____ Last name _____
2. Licence # _____
3. Telephone |__|__|__|__|__|__|__|__|__|__| Ext. |__|__|__|__| 4. Fax |__|__|__|__|__|__|__|__|__|__|
5. Clinic address _____ City _____

   Province _____ Country _____ Postal code _____

6. ☐ Family physician ☐ General practitioner ☐ Specialist, please specify _____

Section G – Consent and Signature (to be completed by the attending physician)

If any of the personal information is inaccurate, incomplete or unclear, the insured person may have it corrected by submitting a request to UV Insurance.

For more details, please see our **Privacy Policy**.

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.

X _____ Date |__|__|__|__|__|__|__|__|

Signature

Note: The cost of completing this application is borne by the insured person.

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