Manulife

CLHIA ACCAP

Initial Disability Insurance Medical Statement

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

Manulife Group Benefits
Attention: Disability Claims
P.O. Box 800 Station Waterloo
Waterloo, Ontario N2J 4C2

Tel: 1-877-481-9169
Fax: 1-866-677-4215
Email: **group_disability_claims@manulife.ca**

1. Patient information and consent **To be completed by the patient**

Patient name (last, first, middle initial): _____

Home phone # (+ area code): ( ) _____

Cell phone # (+ area code): ( ) _____

Address (number, street and suite): _____

City: _____ Province: _____ Postal code: _____

Employer's name (if applicable): _____ Contract or policy #: _____ Certificate # (if applicable): _____ Date of birth (dd/mmm/yyyy): _____

Date last worked (dd/mmm/yyyy): _____	**Date returned to work or expected return to work date** (dd/mmm/yyyy): _____

Please list your present medications:

	Name of medication	Dosage (mg)	How often?
1.			
2.			
3.			
4.			
5.			

Please provide your:
Height: _____
Weight: _____
Dominant hand:
Left ☐
Right ☐

I hereby authorize the release of medical and health information in my file to Manulife 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.

I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

Patient signature: _____ Date of consent (dd/mmm/yyyy): _____

2. Medical statement **To be completed by the doctor** (or applicable medical provider)

I am the: Family physician ☐ Consulting specialist ☐ Other ☐ Please specify: _____

Please complete to the best of your knowledge

Diagnosis:

Primary:

Secondary and/or complications:

If childbirth - expected or actual delivery date (dd/mmm/yyyy): _____ Vaginal ☐ C-Section ☐

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/mmm/yyyy): _____

Continued on the next page.

2. Medical statement (continued) **To be completed by the doctor** (or applicable medical provider)

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/mmm/yyyy): _____	First date of work absence due to condition (dd/mmm/yyyy): _____

Treatment

e.g. Special programs, therapies, medications: (if not noted by patient in **Section 1**):

Frequency of visits: Weekly ☐ Monthly ☐ Other ☐ (describe): _____

Date of last visit (dd/mmm/yyyy): _____ Date of next visit (dd/mmm/yyyy): _____

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

If **yes**, date (dd/mmm/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/mmm/yyyy)	Date of discharge (dd/mmm/yyyy)	Institution name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mmm/yyyy)	Description
1.		
2.		

STOP

- 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/mmm/yyyy)	Description
1.		
2.		

Continued on the next page.

2. Medical statement (continued) **To be completed by the doctor** (or applicable medical provider)

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/mmm/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:

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/mmm/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:

Prognosis

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

Return-to-work

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

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/mmm/yyyy):

Address (number, street and suite):

City: Province: Postal code:

Telephone # (+ area code): ( ) Fax # (+ area code): ( ) Email address:

Signature:

Print