

**Attending Physician's Supplementary Statement**
**CLAIMS DEPARTMENT**
**MONTRÉAL**  
 P.O. BOX 4002 POSTAL STATION B  
 MONTRÉAL, QUÉBEC H3B 4M2

**TORONTO**  
 P.O. BOX 4105 POSTAL STATION A  
 TORONTO, ONTARIO M5W 2P4

**CALGARY**  
 P.O. BOX 210  
 CALGARY, ALBERTA T2P 4M6

*Instructions*  
 1. Please print.  
 2. Part 1 to be completed by patient.  
 3. Part 2 to be completed by physician.  
 4. Any charge for completing this form is the patient's responsibility.

**I Patient authorization**

Patient surname		Policy no.	Certificate no.
Given name(s)		Initial	Date of birth (YYYY/MM/DD)
Address (no., street)			Apt.
City	Province	Postal code	Telephone no. (day)
<p><i>I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Standard Life, permitting the assessment of my claim.</i></p> <p><i>I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life and/or their authorized agents will use the information provided in this form and in my pertinent prior claims under the same plan for the management of my claim and for production of statistical reports.</i></p> <p><i>I consent to the use of my Social Insurance Number as my membership number under the plan as an identifier in Standard Life's database, and that it is my responsibility to contact my employer if I prefer to use another identification number.</i></p> <p><i>I certify that the information contained in this form is true and complete.</i></p> <p><i>A photocopy of this authorization is valid as the original.</i></p>			
Patient signature			Date (YYYY/MM/DD)

**II Attending physician's statement**
**1. Diagnosis (including any complications)**

a) Primary (if psychiatric, please use DSM-IV)

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b) Additional conditions or complications which might affect duration of absence from work

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c) Subjective symptoms (including severity and frequency)

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d) Objective signs (including results of current X-rays, EKG's or laboratory data and any relevant clinical findings)

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**2. Physical impairment**

a) What physical limitations affect the claimant's ability to work? (e.g. limitations with respect to lifting, carrying, bending, walking, standing)

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**3. Mental or nervous impairment (if applicable)**

a) How does patient's mental or nervous impairment affect ability to work?

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b) Has there been psychiatric referral?

 Yes  No

c) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?

 Yes  No

**4. Cardiac (if applicable)**

a) Functional capacity ( <i>American Heart Association</i> ) <input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 3 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation) Please forward results of exercise stress tests, angiogram, or other relevant documentation	b) Blood pressure ( <i>last visit</i> ) <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Systolic</td> <td style="width:50%; text-align: center;">Diastolic</td> </tr> <tr> <td style="border-top: 1px solid black; height: 20px;"></td> <td style="border-top: 1px solid black; height: 20px;"></td> </tr> </table>	Systolic	Diastolic		
Systolic	Diastolic				

**5. Back/Spinal condition (if applicable)**

a) Have an X-ray, MRI, or any other test been performed?  
 Yes (*please attach copies of results of X-rays, MRIs, or other tests*)  
 No

**6. Treatment**

a) Date of latest visit (YYYY/MM/DD)    b) Frequency of visits   
 Weekly   
 Monthly   
 Other (*specify*)

c) Please detail the patient's present treatment (*e.g. date and type of surgery*) as well as response to treatment

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d) Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)
		/ /
		/ /
		/ /

e) To your knowledge is patient following recommended treatment program?  
 Yes     No (*please comment*)

**7. Progress**

Has patient   
 Recovered   
 Improved   
 Not improved   
 Retrogressed

**8. Prognosis**

Do you think that your patient will be able to return to work?    (YYYY/MM/DD)  
 No     Yes (*state approximate date*)    / /

**9. Rehabilitation**

a) Is patient a suitable candidate for further medical rehabilitation services? (*i.e. cardiopulmonary program, etc.*)  
 No     Yes (*specify*)

b) Would vocational counselling and/or retraining be recommended? <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>specify</i> )	c) Is patient suitable for trial employment?    (YYYY/MM/DD) <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>state date</i> )    / /
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**10. Remarks (please provide comments and further details which you feel would be helpful)**

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Name of attending physician ( <i>please print</i> )		Specialty	
Address ( <i>no., street</i> )			Suite
City	Province	Postal code	Telephone no. ( <i>day</i> ) ( )
Attending physician signature		Date (YYYY/MM/DD) / /	