SUPPLEMENTARY DISABILITY REPORT

Forward to: THE BENEFITS TRUST
3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9 Phone: 905-264-8990, 1-800-487-2993 Fax: 905-264-1123

Employee Information

❑ Mr. ❑ Mrs.

Last Name: ______________________ First Name: ______________________ ❑ Ms. ❑ Miss

Address: ______________________ Apt. # __________

City: ______________________ Province: ______________________ Postal Code: __________

Home Telephone: ______________________ Occupation: ______________________

Date of Birth: (Month) ________ (Day) ________ (Year) ________ S.I.N. : ________ - ________ - ________

Name of Employer: ______________________ Business Telephone: ______________________

Are you receiving Employment Insurance Benefits? ______________________

Are you receiving benefits from any other insurance plan? ______________________

Are you receiving Workplace Safety & Insurance benefits? ______________________

Are you in hospital? ______________________

Are you confined to home? ______________________

Are you able to leave your home? ______________________

When do you expect to return to work? ______________________

I hereby certify the above statements are true and I authorize all medical practitioners who may have attended or examined me and all hospitals to furnish The Benefits Trust all information with respect to this claim. Furthermore, The Benefits Trust may use my social insurance number for identification purposes. I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. A photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Employee Signature: ______________________ Date: (M) ________ (D) ________ (Y) ________

Please inform The Benefits Trust as soon as you return to work.

Comments

Attending Physician's Statement of Continuing Disability

1. Patient's name: ______________________ Date of Birth: (M) ________ (D) ________ (Y) ________

2. Diagnosis and Symptomatology (Accurate diagnosis required to cause "total" or "partial" disability, and complications if any).

____

____

3. Present Condition:
   a) Please describe complications, recent surgery or new independent condition(s) which are contributing to the duration of total disability. Include results of current x-rays, E.K.G. or any other special tests.

____

____

   b) Is patient: Ambulatory ❑ Bed confined ❑ House confined ❑ Hospital confined ❑

4. Cardiac (if applicable):
   a) Functional capacity
   Class 1 (no limitation) ❑ Class 2 (slight limitation) ❑
   Class 3 (marked limitation) ❑ Class 4 (complete limitation) ❑

   b) Blood pressure (latest visit) ______________________

5. Nature of treatments including names and dosage of prescribed medications: ______________________

____

6. Treatment program:
   a) Is patient following recommended treatment program? Yes ❑ No ❑ If no, please clarify below in "Remarks"

   b) Date of latest treatment: (M) ________ (D) ________ (Y) ________

   c) Frequency of visits: Weekly ❑ Monthly ❑ Other ❑ (specify) ______________________

7. Extent of disability:
   a) Is patient now totally disabled for regular duties? Yes ❑ No ❑ Any other duties? Yes ❑ No ❑

   b) If no, when was patient able to resume regular duties:
   (M) _______ (D) _______ (Y) _______ Any other duties? (M) _______ (D) _______ (Y) _______

   c) If yes, when should patient be able to resume regular duties:
   (M) _______ (D) _______ (Y) _______ Any other duties? (M) _______ (D) _______ (Y) _______

   d) If indefinite, the estimated number of additional weeks / months before patient's return to work: _______weeks _______months.

   e) Is patient now partially disabled? Yes ❑ No ❑ If yes, since when? (M) _______ (D) _______ (Y) _______

   f) Is patient a suitable candidate for some form of accommodated or modified work? Yes ❑ No ❑

8. Remarks: ______________________

____

____

Physician Signature: ______________________ Date: (M) ________ (D) ________ (Y) ________

Name (please print): ______________________ Telephone: ______________________

Address: ______________________

IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE PATIENT'S RESPONSIBILITY