SUPPLEMENTARY DISABILITY REPORT

the benefits trust

Forward to: THE BENEFITS TRUST
1453 Pelham St, Fonthill, Ontario, L0S 1E0 Phone: 905-264-8990, 1-800-487-2993 Fax: 905-264-1123

Employee Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

Addr es s: _____ 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): _____ T el ep ho ne: _____

Addr es s : _____

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