Manulife

# Initial Attending Physician's Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

---

***An incomplete form may result in delays in the adjudication of your patient's disability claim.***

***Please see page 2 for instructions.***

**The LTD eligibility process**

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

**Patient authorization**

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 3 before it can be submitted to Manulife.

**What do we need from you?**

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

**Payment responsibility**

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

**Submitting forms**

You may give the completed form to your patient or send it directly to Manulife, Group Disability Benefits, at the address indicated below.

**Manulife Group Benefits**
**Attention: Disability Claims**
**PO BOX 1030 STN CENTRAL**
**HALIFAX NS B3J 2X5**
**email: group_disability_claims@manulife.ca**
**Tel: 1-800-565-0627**
**Fax: 1-866-292-9050**

**www.manulife.ca/planmember**

Manulife

Nova Scotia Public Service
Long Term Disability Plan Trust Fund

# Group Benefits
# Initial Attending Physician's Statement
## Group Disability Claim

### 1 Patient authorization

To be completed by patient.

Name (last, first, initial)

Plan contract number **84560**

SIN

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of this form.**"

Patient's signature

Date (dd/mmm/yyyy)

### 2 Attending physician's statement

**Diagnosis**

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) ***If*** psychiatric disorder, provide current GAF score.

GAF score

d) ***If*** cardiac disorder, provide American Heart Association functional classification.

◯ Class I (No limitation) ◯ Class II (Slight limitation)
◯ Class III (Marked limitation) ◯ Class IV (Complete limitation)

### 3 Clinical information

***Please note that we need you to identify your patient's limitations and the impact of those on your patient's functional capabilities. To enable our adjudicators to assess the disability arising from these limitations, please provide supportive documentation such as reports, chart notes and test results.***

a) What date did symptoms first appear/accident happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

◯ Injury ◯ Work-related ◯ Motor vehicle accident ◯ Other (specify)
◯ Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)

Date of latest visit (dd/mmm/yyyy)

Frequency of visits

◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Other (specify)

e) What are the patient's subjective ***symptoms***?

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity)

g) What were your initial ***clinical findings***?

h) What are your most recent ***clinical findings***?

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

◯ Ambulatory
◯ Ambulatory with assistive devices
◯ Bed confined
◯ Home confined
◯ Hospital confined

k) What is the patient's current height and weight, and dominant hand?

| Current height | Current weight | Dominant hand |
|---|---|---|
| | | ◯ Left ◯ Right |

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

| Reading | Date read (dd/mmm/yyyy) |
|---|---|
| | |
| | |
| | |

m) ***If*** patient is visually impaired, provide vision and date of last examination.

| With corrective lenses | Without corrective lenses | Date of last exam (dd/mmm/yyyy) |
|---|---|---|
| OD OS | OD OS | |

n) ***If*** patient is pregnant, give date of EDC.

| Date of EDC (dd/mmm/yyyy) |
|---|
| |

## 4 Diagnostic investigations

***Please enclose copies of any and all consultation and diagnostic investigative reports (x-rays, scans, laboratory data, etc.)***

## 5 Treatment

a) Names of other treating/ consulting physicians or health care practitioners:

| NAME OF PRACTITIONER | TYPE OF PRACTITIONER | DATE SEEN or TO BE SEEN (dd/mmm/yyyy) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

b) Current medications

| NAME | DOSAGE | DURATION | START DATE (dd/mmm/yyyy) | RESPONSE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

c) Other forms of treatment or therapies

| TYPE | DURATION | START DATE (dd/mmm/yyyy) | RESPONSE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

d) Hospitalizations:

| ADMISSION DATES (dd/mmm/yyyy) | DISCHARGE DATES (dd/mmm/yyyy) | FACILITY | REASON (date of surgery if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

e) Treatment response:

◯ Recovered
◯ Improved
◯ No change
◯ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

◯ Yes ◯ No

***If no, please elaborate:***

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

## 6 Competency

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

◯ Yes ◯ No ***If no, from what date?***

Date (dd/mmm/yyyy)

## 7 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

◯ Yes ◯ No

***If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?***

Date (dd/mmm/yyyy)

## 7 Remarks

**Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.**

Name of attending physician (please print)

Specialty | Telephone (include area code) | Fax (include area code)

Address (number, street and suite)

City | Province | Postal code

Signature | Date signed (dd/mmm/yyyy)

Print

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.