CLHIA ACCAP

Sun Life

Initial Disability Insurance Medical Statement

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

Section 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 (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd-mm-yyyy)

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date** (dd-mm-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 _____ (Insurance Company) 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/mm/yyyy)

Section 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/mm/yyyy): _____ Vaginal ☐ C-Section ☐