Clear

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)
Peter Julius Fern	613 656 5890	647 666 8888

Address (Street, City, Province, Postal Code): 45 Maple Ave, Toronto, ON, K7L 3V8

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd-mm-yyyy)
None	9696178816	None	15 04 1960

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date** (dd-mm-yyyy)
Non Non None	Non Non None

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.	Aspirin	81	once a day
2.	Metoprolol	25	twice daily
3.	Nitroglycerin	0.4	as needed for ches
4.	None	None	None
5.	None	None	None

Please provide your:

Height: None

Weight: None

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to None (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) None

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: stable angina

Hypertension

Secondary and/or Complications: GERD

Hyperlipidemia

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Non Non None Vaginal ☐ C-Section ☐