Manulife

Colleges, Universities and Institutes Benefits Consortium

Group Benefits
Attending Physician Statement
Abilities Management Access

The purpose of this Statement is to assist Manulife in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. ***PLEASE KEEP A COPY FOR YOUR RECORDS.***

Manulife Group Benefits
Attention: Disability Claims
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1

Tel: 1-800-575-2200
Fax: 1-866-413-3582
Email: Vancouver_group_disability_claims@manulife.ca

1 Plan member/employee information and consent (To be completed by patient.)

Plan member/employee name (last, first, middle initial)	Home phone number ( )	Cell phone number ( )

Address (number, street, apt.)	City	Province	Postal code

Plan sponsor name	Plan contract number	Plan member certificate number

Height	Weight	Date of birth (dd/mmm/yyyy)

Last date worked (dd/mmm/yyyy)	**Date returned to work or expected return to work date** (dd/mmm/yyyy)

I hereby authorize the release of medical and health information in my file to Manulife and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. 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 may not be assessed. **I understand** that I am responsible for any fees related to the completion of this form. **I agree** that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Plan member/Employee signature _____ Date (dd/mmm/yyyy) _____

2 Attending physician's statement

STOP

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the *last date worked*, complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary:

Secondary:

If childbirth provide expected or actual delivery date (dd/mmm/yyyy) _____

Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☐

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☐ Date admitted (dd/mmm/yyyy): _____

Name of institution: _____ Date discharged (dd/mmm/yyyy): _____

If surgery was performed provide date and description of surgery.
Date (dd/mmm/yyyy): _____ Description: _____

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☐ | If *yes*, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other _____

Attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit _____

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

To your knowledge, is the patient following the recommended treatment program? Yes ☐ No ☐

Do you have concerns about the patient's ability to manage their own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a 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 I consent to such unedited release of any information contained herein.

Attending physician (please print)	Certified specialist		Physician's stamp
Address (number, street, suite)			
City	Province	Postal code	
Telephone number ( )	Fax number ( )		
Signature		Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.