HEALTHCARE BENEFIT TRUST HBT BENEFIT FROM EXPERIENCE

canada life™

Healthcare Benefit Trust (HBT) Policy #51337 ☐
Joint Community Benefits Trust (JCBT) Policy #59234 ☐
Joint Facilities Benefits Trust (JFBT) Policy #59233 ☐
Joint Health Science Benefits Trust (JHSBT) Policy #59232 ☐
Community Social Services Employers' Association (CSSEA) Policy #51367 ☐
Healthcare Benefit Trust (HBT) Policy #50168 ☐

Claim for Long Term Disability Benefits

ATTENDING PHYSICIAN'S STATEMENT OF CONTINUING DISABILITY – FORM C

This form may be mailed directly to Canada Life at the address indicated below, or given to the patient at the physician's discretion. The patient is responsible for any charges made for its completion.

☐ **Vancouver: Suite #1500 – 1055 Dunsmuir Street, Vancouver, BC V7X 1K8**

☐ **Langley: Suite #500 – 19933 – 88th Avenue, Langley, BC V2Y 4K5**

☐ **Calgary: Suite #1700 – 530 8 Ave SW, Calgary, AB T2P 3S8**

Patient's Name _____ **Division Number** | | | | **HBT Benefits ID No. (BID)** _____

Physician – Important Notice

The detailed completion of this form is of vital importance to the patient, as this medical evidence is essential to enable the patient's disability claim to be processed. Please complete the sections relating to your patient and strike out non-applicable areas. The back page is available to expand on comments under any of the headings or to add other information relevant to the claim. Copies of this form and other medical reports will be released to the patient when requested in writing by the patient.

Physician's Name: _____ (Please Print) **Telephone #:** _____

Address: _____ (Number & Street / City / Province / Postal Code)

Signature: _____ **Date:** _____

Specialty, if applicable: _____

Claimant's Authorization

I hereby authorize the release to Canada Life and to the Trustees of the Trust and their agents of any information in respect of this claim. I understand that I am responsible for any charges that may be made for the completion of this form.

Signature: _____ **Date:** _____

1. Diagnosis

a) Primary _____

_____

_____

_____

b) Secondary (if applicable) _____

_____

_____

_____

To what extent does the secondary diagnosis contribute to the patient's condition?

☐ Significantly ☐ Equally with primary diagnosis ☐ Slightly ☐ Not a contributing factor

2. Present Condition

a) Date of examination these findings are based on | Day | Month | Year |

b) Please describe complications, recent surgery or new independent conditions which are contributing to the duration of disability.

c) Height: _____ Weight: _____

d) Is Patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

e) Supporting clinical evidence of present condition (detailed description of physical findings, lab tests, consultation reports). **(Please attach copies of current X-ray reports, E.K.G. reports or other test results and reports).**

3. Cardiac Condition

a) Functional capacity (American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

b) Blood Pressure (latest visit): _____

4. Progress

Has patient: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed

5. Treatment

a) Present Treatment _____

b) Medication (names and dosages) _____

5. Treatment (continued)

c) Future Treatment Plan

d) Prognosis

e) Date of first visit Day Month Year Date of last visit Day Month Year

f) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify):

g) Is patient following recommended treatment program? ☐ Yes ☐ No If "No", please comment:

h) Other treating and consulting physicians/specialists:

Name	Specialty	Date of Latest Visit

6. Prognosis

a) Medically able to return to work at **own** occupation.

☐ Full-Time ____ Day ____ Month ____ Year

☐ Part-Time ____ Day ____ Month ____ Year

b) If medically unable to return to **own** occupation, when will patient be able to seek other employment?

☐ Full-Time ____ Day ____ Month ____ Year

☐ Part-Time ____ Day ____ Month ____ Year

c) If indefinite, estimate the number of additional weeks/months before patient's return to work. _____ Weeks _____ Months

d) Describe the current restriction and or limitations. _____

e) Would the services of a rehabilitation consultant be useful to assist your patient to return to work? ☐ Yes ☐ No

f) Is patient a suitable candidate for some form of trial employment or retraining? ☐ Yes ☐ No

If "Yes", please comment: _____

7. Additional Information

Supporting Clinical Evidence	Attached	Unavailable
a) Consultation Reports	☐	☐
b) Lab Tests	☐	☐
c) Diagnostic Test Results	☐	☐
d) Clinical Notes	☐	☐
e) Other Test Results and Reports	☐	☐

Remarks