ATTENDING PHYSICIAN'S STATEMENT – DISABILITY CLAIM



SSQ, Life Insurance Company Inc. | Disability Management & Life Insurance 2525 Laurier Boulevard | P.O. Box 10500 | Station Sainte-Foy | Quebec (Quebec) G1V 4H6 418-651-2307 or 1-888-651-2307 | Fax: 418-651-5569

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

Plan Member/Employee Infor		To Be Completed By Patient							
Male Plan Member/Employee Name :									
□ Male □ _{Female} Plan Member/Employee Name :	First Name								
Date of Birth	Height	Weight	Home Phone # (+ Area Code)		Cell Phone # (+ Area Code)				
Y Y Y Y M M D D									
Address									
Street		City		Province Postal Code Member Certificate #					
Employer's Name		Plan Contract #							
Last Date Worked		Date Returned to Work or Expected Return to Work Da							
Y Y Y Y M	M D D	ΥΥΥ	Y M M I	D D					
Questions				То	Be Complete	ed By Physician			
 If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete sections 1 to 4 only and sign the end of the form. For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full. 									
1) Diagnosis									
Primary Diagnosis:									
Secondary and/or Complications:									
Does the interruption of work result from	n problems related to:	:							
□ marital/family life □ personnal or interpersonnal problems □ alcohol or drug abuse and/or gambling problems									
If Childbirth - Expected or Actual Delivery	y Date Y Y Y Y Y	M M D D Va	aginal 🔲 C-Section 🗌						
Occupational Illness/injury? Yes		Auto accident? 🗆 Yes 🗆] No						
If yes, date of event: <u>Y Y Y Y M M D D</u>			If yes, date of event: Y Y Y Y M M D D						
Date of first visit to you pertaining to this condition:			First date of work absence due to condition:						
			Y ₁ Y ₁ Y ₁ Y M ₁ M D ₁ D						
2) Hospitalization									
Is/was patient hospitalized? \Box or had da	ay surgery? 🗆								
Y Y Y Y M M D D									
	Date of discharge		titution Name						
If surgery was performed please provide	date and description	of surgery:							
Date	Description								
3) Treatment (drug, dosage, physioth	nerapy, other):								

4) Prognosis Please provide the prognosis for recovery:				
Has the patient been treated for this same or similar condition in the past? \Box Yes	□ No			
If yes, date: <u>Y Y Y Y M M M D D</u> Treatment Provider:				
Please describe the patient's symptoms including history and frequency:				
Degree of severity of all symptoms:				
\square Mild \square Moderate \square Severe \square with psychotic elements				
Frequency of Visits: Weekly \Box Monthly \Box Other \Box				
Approximate duration of disability: No. of days No. of weeks unspecified or date of return to work Y Y Y M M D D D part-time full-time gradual return Specify:				
5) Continuation of Attending Physician's Statement for Absence	es that ma	ay be Gre	ater than 4 Weeks	
 Please attach copies of all relevant: test results/investigations (If test results are not attached, w consultation reports If consultation report is not attached, please indicate if your patient has one of the second secon			pecialist for this condition	on.
Name of Specialist Specialty			Date of Vis	Y
Based on your clinical findings and observations, please describe the patient's current	cognitive ar	nd/or physica	al restrictions and limitation	5:
Please list any complications and additional conditions impacting your patient's level of	function or t	he expected	recovery period:	
Is the patient following the recommended treatment program?	□ Yes	□ No		
Do you have concerns about the patient's ability to manage his/her own affairs?	□ Yes	□ No		
Notice to Physician The information in this statement will be kept in a life, health, or disability benefits file or third parties to whom access has been granted or those authorized by law.	e with the in	surer or plar	n administrator and might b	e accessible by the patient
Name of Attending Physician			Date Signed : $\begin{array}{c} Y \\ Y \end{array}$	Y Y M M D D
Physician's Specialty			_ License Number:	
Address: City			Province	Postal Code
Telephone # (+ area code):	e):			
Signature:				