SSQ Financial Group

Values in the right place

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 Information and Consent — To Be Completed By Patient

☐ Male
☐ Female

Plan Member/Employee Name : _____
Last 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

Employer's Name	Plan Contract #	Member Certificate #

Last Date Worked	**Date Returned to Work or Expected Return to Work Date**
Y Y Y Y M M D D	Y Y Y Y M M D D

Questions — To Be Completed By Physician

STOP

- **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: _____

If Childbirth - Expected or Actual Delivery Date Y Y Y Y M M D D ☐ Vaginal ☐ C-Section

Occupational Illness/injury? ☐ Yes ☐ No
If yes, date of event: Y Y Y Y M M D D

Auto accident? ☐ Yes ☐ No
If yes, date of event: Y Y Y Y M M D D

Date of first visit to you pertaining to this condition: Y Y Y Y M M D D

First date of work absence due to condition: Y Y Y Y M M D D

2) Hospitalization

Is/was patient hospitalized? ☐ **or** had day surgery? ☐

Y Y Y Y M M D D — Date of admittance
Y Y Y Y M M D D — Date of discharge
_____ Institution Name

If surgery was performed please provide date and description of surgery:

Y Y Y Y M M D D — Date
_____ Description

3) Treatment (drug, dosage, physiotherapy, other):

4) Prognosis Please provide the prognosis for recovery:

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: Y Y Y Y M M D D Treatment Provider:

Please describe the patient's symptoms including history, severity and frequency:

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐

5) Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Please attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **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 (Y Y Y Y M M D D)

Based on your clinical findings and observations, please describe the 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:

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 with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician (please print) Date Signed : Y Y Y Y M M D D

Physician's Specialty License Number:

Address: Street City Province Postal Code

Telephone # (+ area code): Fax # (+ area code):

Signature: