Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

DISABILITY BENEFITS ATTENDING PHYSICIAN'S STATEMENT CANCER

To allow us to make an assessment of your patient's claim, please answer all of the questions in full.

Instructions:
1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

Part 1: Patient Authorization

Policy Number: ____ Certificate Number: ____ Claim Number: ____

Name ____ Date of Birth DD / MM / YYYY

Address (number, street, city, province and postal code)

Phone Number (include area code)

I hereby authorize the release to Equitable Life of Canada® any information requested by Equitable Life of Canada in respect of this claim.

Patient's Signature ____ Date DD / MM / YYYY

Part 2: Attending Physician's Statement

1. Diagnosis (including any Complications) please attach a copy of all consultation, operative and pathology reports:

Date of cancer diagnosis: DD / MM / YYYY

Site of Tumour/Metastases:

Type of tumour:

Grade and staging

2. History (please attach a copy of your clinical notes relating to this period of disability)

Date symptoms first appeared: DD / MM / YYYY

Has patient ever had same or similar condition? ❑ Yes ❑ No ❑ Unknown

If yes, please specify diagnosis and dates of treatment: DD / MM / YYYY

Describe current symptoms/history:

First visit for these symptoms: DD / MM / YYYY

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3. Current height Current weight Weight loss/gain in past 6 months

4. Date patient stopped working due to this condition. DD / MM / YYYY

5. Treatment

Date of first visit: DD / MM / YYYY

Date of most recent visit: DD / MM / YYYY

Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (specify)

Treatment: Include information on all treatments to date and future treatment plan, inclusive of:
Surgery:

Medication/Hormonal:

Chemotherapy/Radiation:

6. Hospitalization

Date of in-patient admission: DD / MM / YYYY

Date of discharge: DD / MM / YYYY

Date of out-patient treatment: DD / MM / YYYY

Name of hospital:

7. Describe response to therapies to date: ❑ N/A ❑ partial ❑ complete

Describe any other conditions that may prolong recovery.

Describe any "post therapy" complications.

Prognosis:

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8. Is the condition due to injury or sickness arising out of the patient's employment? ❑ Yes ❑ No
   If yes, has your office filed a claim for this condition with the WCB/WSIB on behalf of your patient? ❑ Yes ❑ No

9. Please indicate your patient's current physical abilities:

❑ Sedentary Duties: Exerting up to 10 pounds (4.5 kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary Duties involve sitting most of the time, butmay involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

❑ Light Duties:Exerting up to 20 pounds (9.1 kg) of force occasionally and/or up to 10 pounds (4.5 kg) of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Duties. Light Duties usually require walking or standing to a significant degree. However, if the use of the arm and/or leg controls requires exertion of forces greater than that for Sedentary Duties and the worker sits most of the time, the job is rated Light Duties.

❑ Medium Duties:Exerting up to 50 pounds (22.7 kg) of force occasionally, and/or up to 25 pounds (11.3 kg) of force frequently, and/or up to 10 pounds (4.5 kg) of force constantly to move objects.

❑ Heavy Duties:Exerting up to 100 pounds (45.4 kg) of force occasionally, and/or up to 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects

❑ Very Heavy Duties:Exerting in excess of 100 pounds (45.4 kg) of force occasionally, and/or in excess of 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (91 kg) of force constantly to move objects.

In your opinion, what is the earliest date your patient will be able to return to work?	DD / MM / YYYY
If the previous job could be modified, when could rehabilitation employment commence?	DD / MM / YYYY

10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; and copies of any available consultation reports.

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11. Do you believe patient is competent to cash cheques and use the proceeds? ❑ Yes ❑ No
If no, why not?

12. Have you referred the case to the Public Trustee? ❑ Yes ❑ No
We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

13. Have you completed other requests regarding your patient's current medical condition to other sources, i.e. other insurance providers, Canada Pension Plan, WSIB/WCB, etc.? ❑ Yes ❑ No
If so, please provide details:

Name of Physician (please print)

Specialty:

Telephone: Fax:

Address (number, street, city, province & postal code):

Physician's signature Date:

Please keep a copy of this form for your records. **Please do not use staples.** Send this completed form, along with any other pertinent documentation, to:

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Alternatively, you can **scan** and **email** the forms to 'group-disability-claims@equitable.ca'.
Or **fax** your documents to 519.883.7406 or fax toll free to 1.888.505.4373

REMEMBER, while using the Internet and e-mail is convenient, sending your confidential and personal information through the Internet is not secure. E-mail is vulnerable to interception. Equitable cannot ensure the privacy of information sent by e-mail.

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