canada life™

51292/51295

ATTENDING PHYSICIAN'S STATEMENT

Transit Employees' Health and Benefit Trust

1. PATIENT'S NAME: _____ DATE OF BIRTH: _____ (YEAR / MONTH / DAY)

2. EMPLOYEE NUMBER: _____ SENIORITY NUMBER: _____

CURRENT HEIGHT: _____ CURRENT WEIGHT: _____

3. DIAGNOSIS (INCLUDING ANY COMPLICATIONS)

PRIMARY _____

SECONDARY _____

SUBJECTIVE SYMPTOMS: _____

OBJECTIVE SIGNS (INCLUDING RESULTS OF CURRENT X-RAYS, BLOOD PRESSURE, LABORATORY DATA AND ANY RELEVANT CLINICAL FINDINGS):

_____

_____

_____

4. HOSPITALIZATION, IF APPLICABLE FOR THIS ILLNESS OR INJURY:

DATE OF IN-PATIENT ADMISSION: _____ (YEAR / MONTH / DAY) DATE OF DISCHARGE: _____ (YEAR / MONTH / DAY)

DATE OF OUT-PATIENT TREATMENT: _____ (YEAR / MONTH / DAY)

NAME OF HOSPITAL: _____

☐ REGISTERED BED PATIENT?

FROM: _____ (YEAR / MONTH / DAY) TO: _____ (YEAR / MONTH / DAY)

☐ DAY SURGICAL PATIENT _____ (YEAR / MONTH / DAY)

☐ KIDNEY DIALYSIS

FROM: _____ (YEAR / MONTH / DAY) TO: _____ (YEAR / MONTH / DAY)

☐ CHEMOTHERAPY

FROM: _____ (YEAR / MONTH / DAY) TO: _____ (YEAR / MONTH / DAY)

☐ RADIATION THERAPY

FROM: _____ (YEAR / MONTH / DAY) TO: _____ (YEAR / MONTH / DAY)

☐ EMERGENCY WARD (O.P.) _____ (YEAR / MONTH / DAY)

5. SURGERY

SURGICAL PROCEDURE PERFORMED: _____

DATE OF SURGERY: _____ NAME OF SURGEON: _____

6. HISTORY

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED. _____ (YEAR / MONTH / DAY)

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY DIAGNOSIS AND DATES. _____

_____

7. TREATMENT

WHAT IS THE CURRENT TREATMENT REGIMEN? (DRUG DOSAGE, PHYSIO, OTHER AND PROGRESS) _____

_____

_____

PLEASE INDICATE ALL DATES OF VISITS FOR THE CURRENT CONDITION:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

8. IF CONDITION IS DUE TO PREGNANCY, WHAT IS (OR WAS) THE EXPECTED DATE OF CONFINEMENT?
YEAR MONTH DAY

9. IN YOUR OPINION, WHEN DID THE PATIENT'S CONDITION FIRST PREVENT HIM/HER FROM WORKING?
YEAR MONTH DAY

10. 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 WORKSAFE BC ON BEHALF OF THE PATIENT?
☐ YES ☐ NO

11. WHAT ARE THE SIGNIFICANT IMPAIRMENTS PREVENTING THE PATIENT FROM WORKING TODAY?

WHEN, IN YOUR OPINION WILL YOUR PATIENT BE ABLE TO: RETURN TO WORK AT THEIR OWN OCCUPATION?
YEAR MONTH DAY

RETURN TO MODIFIED DUTIES?
YEAR MONTH DAY

RETURN TO ALTERNATE DUTIES?
YEAR MONTH DAY

IF YOUR PATIENT IS CAPABLE OF MODIFIED/ALTERNATE DUTIES, PLEASE INDICATE THEIR RESTRICTIONS

12. PLEASE PROVIDE THE NAMES OF OTHER PHYSICIANS WHO HAVE BEEN/WILL BE INVOLVED IN ASSESSING THE MEDICAL PROBLEMS.

13. WE WOULD APPRECIATE ANY ADDITIONAL COMMENTS YOU WOULD CARE TO MAKE THAT WOULD HELP US TO BETTER UNDERSTAND YOUR PATIENT AND THE PROBLEMS FACED.

NAME OF PHYSICIAN (PLEASE PRINT) SPECIALTY

ADDRESS: TELEPHONE NUMBER

PHYSICIAN'S SIGNATURE DATE

Protecting Your Personal Information
At **Canada Life**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. This information about you may include medical and psychiatric information. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s) to administer coverage that you may have with Canada Life. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.
I authorize:

- Canada Life, any healthcare or rehabilitation provider, the Occupational Health Group and the Trustees of the Transit Employees' Health and Benefit Trust, any other insurance or reinsurance companies, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Canada Life or the above to exchange information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Canada Life and administering the group benefits plan. This may include performing independent assessments;
- Canada Life to exchange my personal information with the Occupational Health Group and the Trustees of the Transit Employees' Health and Benefit Trust when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Canada Life to disclose, at any time, personal information about my claim(s) to the Trustees of the Transit Employees' Health and Benefit Trust, their agent, or by Canada Life for the purpose of auditing the assessment of claims.
- Canada Life to disclose my personal information with the Occupational Health Group and Trustees of the Transit Employees' Health and Benefit Trust for the purpose of assisting with the assessment of my claim(s) and when relevant for any internal appeal process;
- Canada Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that my personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Canada Life and to administer the group benefits plan. I acknowledge that my consent enables Canada Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

I consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes. This consent may be revoked by me at any time by sending a written instruction. I acknowledge that withdrawing my consent may result in delay or denial of my claim.

Except for audit purposes the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

In the event that, through my receipt of benefits under this plan an overpayment occurs and I have not refunded such overpayment to Canada Life directly I authorize the deduction of such overpayment from any amounts owing to me, including, without limitation, income from employment.

Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approval.

Print Name Signature

Date Telephone Number

EMAIL ADDRESS (enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim)

Clear