Desjardins Insurance
LIFE • HEALTH • RETIREMENT

PO Box 1024 STN A
Toronto ON M5W 1G5

Tel.: 604-718-4422 or 1-877-718-4422
Fax: 604-678-8124 or 1-855-678-8124

PPWC Public and Private Workers of Canada
PPWC - Employer Trusteed Health & Welfare Plan
Participating Employers of the Plan

GROUP INSURANCE - DISABILITY CLAIMS

PHYSICIAN'S STATEMENT — LONG TERM DISABILITY

Policy Number 647049

I authorize my employer to maintain a copy of this form ☐ **Yes** ☐ **No**

Employee's signature:

This form must be completed by the attending physician in full to avoid delays in processing of claim. Please attach any other reports you feel may be helpful in order to expedite the claim review process.
This form must be mailed or faxed directly to Desjardins Financial Security Life Assurance Company (DFS), hereinafter Desjardins Insurance,or given to the patient at the physician's discretion. DFS's address is: **Desjardins Insurance, Disability Claims, PO Box 1024 STN A,Toronto, ON, M5W 1G5**. DFS's fax number is: 604-678-8124. If this form is faxed, please mail originals. Any questions should be directed to DFS at: 604-718-4422 or 1-877-718-4422.

SECTION 1 General information and history

Patient's last name and first name

When did you first see the patient for this disability? YYYY MM DD	When did you last see this patient for the disability? YYYY MM DD

How often are the patient's appointments? **Weekly:** _____ **Bi-Weekly:** _____ **Monthly:** _____ **Other (please specify):** _____

SECTION 2 Diagnosis (Please attach additional information if necessary.)

Primary diagnosis:

Secondary diagnosis:

Subjective symptoms:

Objective medical findings (including results of x-rays, laboratory data, etc.):

SECTION 2 Diagnosis (Continued)

Based on your medical findings and other relevant information please describe the functional limitations and restrictions placed on the patient:

Date of accident or appearance of symptoms: YYYY MM DD

Is the disability a result of a motor vehicle accident? ☐ Yes ☐ No

Is the patient's condition a result of work-related injury or sickness? ☐ Yes ☐ No

Comments:

Has the patient had the same condition or a similar condition previously? ☐ Yes ☐ No

If yes, please describe:

If yes, please state when: YYYY MM DD

SECTION 3 Treatment plan

Has the patient been hospitalized as a result of the disability? ☐ Yes ☐ No

If yes, hospitalization dates From: To:

If yes, where?

If yes, under whose care?

Was surgery performed? ☐ Yes ☐ No If yes, please provide the following details:

Date	Type of surgery	Outcome

Please list prescribed medications, including dosage, frequency and the dates of any changes (including medications prescribed in a hospital):

To your knowledge, has the patient complied with this treatment? ☐ Yes ☐ No

Was any psychological treatment recommended? ☐ Yes ☐ No

If yes, please describe the frequency and duration:

To your knowledge, has the patient complied with this treatment? ☐ Yes ☐ No

SECTION 3 Treatment plan (Continued)

Was physiotherapy/chiropractic treatment recommended? ☐ Yes ☐ No

If yes, please describe the frequency and duration:

To your knowledge, has the patient complied with this treatment? ☐ Yes ☐ No

What other ongoing treatments were recommended?

To your knowledge, has the patient complied with this treatment? ☐ Yes ☐ No

Please list the names and specialties of all other treating physicians and/or practitioners including appointment dates:

Name	Specialty	Appointment date

SECTION 4 Prognosis and return to work plan

Are there any factors (including psychological or other) delaying the patient's recovery or return to work?

☐ Yes ☐ No

Please describe:

How would you describe the patient's progress since he or she stopped working? **Improved:** _____ **Unchanged:** _____ **Regressed:** _____

What is the patient's current status? **Ambulatory:** _____ **House Confined:** _____ **Bed Confined:** _____ **Hospital Confined:** _____

Is the patient a suitable candidate for further medical rehabilitation services (e.g., cardiopulmonary program, speech therapy, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

SECTION 4 Prognosis and return to work plan (Continued)

Would vocational counselling and/or retraining be recommended? ☐ **Yes** ☐ **No**

If the employee wishes to pursue modified duties, you will be contacted for additional information regarding limitations and restrictions.

SECTION 5 Signature

Name of attending physician (PLEASE PRINT)	Speciality

Telephone	Fax	Email address
( ) -	( ) -	

Address	City	Province	Postal code

Physician's signature: **Date:**

NOTE TO PHYSICIAN

Rehabilitation support may be available from the claimant's employer or from the PPWC - Employer trusteed health and welfare plan. This may include health benefits, an employee assistance plan and coordination of a rehabilitation plan. Additional information is available from the claimant or claimant's employer.

PRINT NEW REQUEST