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 — WEEKLY INDEMNITY

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

First day patient seen for this condition: YYYY MM DD

Was the employee hospitalized overnight (or was an invasive surgery performed that would customarily be done in a hospital setting) or was surgery performed which necessitated time off work? ☐ **Yes** ☐ **No** If yes ⇨

If yes, date of hospitalization: YYYY MM DD

If yes, date of surgery: YYYY MM DD

Was the patient referred to you? ☐ **Yes** ☐ **No** If yes ⇨

If yes, name of referring physician:

Have you referred the patient? ☐ **Yes** ☐ **No** If yes ⇨

If yes, name of physician(s)/other practitioner(s):

Did you recommend that the patient stop work? ☐ **Yes** ☐ **No** If yes ⇨

If yes, as of what date? YYYY MM DD

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.)

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 due to a work-related injury or illness? ☐ **Yes** ☐ **No**

Comments:

SECTION 3 Treatment plan

Please list medications you have prescribed or recommended, including dosage and frequency and other recommended treatments:

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

SECTION 4 Prognosis and return to work plan

What is the prognosis?

When will the patient be able to return to regular duties?

YYYY MM DD

Are there any factors (including psychological or other) delaying the patient's recovery or return to work? ☐ **Yes** ☐ **No**

Please describe:

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