FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Supplementary
Attending Physician's Statement (APS)
Long Term Disability
Manulife Group Policy
901102 / 911104 / 911105

Manulife™

Part I — TO BE COMPLETED BY PATIENT/CLAIMANT

LTD Claim No. _____

1. MEMBER INFORMATION

Service Number (SN)	Surname	First Name	Initials

Mailing Address	Home Phone

PO Box, Rural Route, etc.	(circle) Work / Cell Phone

City	Province	Postal Code	Email address

2. DECLARATION AND AUTHORIZATION BY PATIENT/CLAIMANT

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied as a result of my providing false, incomplete or misleading information.

I authorize Manulife and/or SISIP Financial to conduct such investigations concerning this claim for Long Term Disability benefits as they may require.

I understand that, during the course of their investigations, Manulife and/or SISIP Financial will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information").

My Personal Information may be used for the following purposes, where Manulife and/or SISIP Financial deem it necessary for:

- the evaluation of this or any other claim for benefits or applications for insurance that I may have with SISIP Financial;
- administering the policy under which my claim has been made;
- medical case study or review.

I therefore authorize Manulife, SISIP Financial and the following persons, institutions and organizations, to provide to and exchange with each other, any of my Personal Information which they have in their possession or control:

- any physician, health care practitioner, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment:
- any provincial health insurance plan, insurance company, reinsurer;
- any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits;
- any federal or provincial government agency, department or organization;
- any investigative or security agency, personal information agent or any other person, agency or institution having my Personal Information.

I understand that any Personal Information that I provide, or which Manulife and/or SISIP Financial has collected, will be kept by Manulife and/or SISIP Financial in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife and/or SISIP Financial and other persons (corporate or individual), firms or agencies engaged by Manulife and/or SISIP Financial, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law.

I understand that where Manulife and/or SISIP Financial has obtained sensitive medical information from someone other than my physician, Manulife and/or SISIP Financial will only release such information through my physician.

I understand and agree that this authorization shall continue as long as the claim for which this authorization has been completed exists, or services for this claim are required from Manulife. A copy of this authorization shall be as valid as the original.

The information provided on this form is protected from unauthorized disclosure under *Canada's Privacy Act, Personal Information Protection and Electronic Documents Act* or equivalent provincial legislation and is available to you upon request.

_____ _____
Patient/Claimant Signature Day Month Year

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN

COMPLETION INSTRUCTIONS TO PHYSICIAN

Please provide all information and documentation as required on this form so that we can better understand the extent of your patient/claimant's illness and the resulting impairments. The information provided will form the basis upon which continuing entitlement to benefits will be assessed.

Instructions:
1) Please Print.
2) Return completed form and attachments to your patient/claimant or directly to Manulife, SISIP Services, 2727 Joseph Howe Drive, PO Box 1030, Halifax NS B3J 2X5.
3) **Any charge for completing this form is your patient/claimant's responsibility.**

Patient/Claimant Identification:

Service Number (SN)	Surname	First Name	Initials

1. DIAGNOSIS – (Please do not use subjective descriptions i.e. pain, etc.)

Please provide copies of any relevant medical evidence (e.g., specialist consultation letters, visitation/chart notes, assessment reports, hospital discharge summaries, operative reports, etc.) that will assist in clarifying your patient's health status.

Current primary disabling diagnosis: _____

Active physical health conditions (other than above primary diagnosis): _____

_____

Active psychiatric conditions (other than above primary diagnosis): _____

_____

List your patient's active symptoms: _____

_____

List your patient's active, objective clinical findings: _____

_____

List all relevant, objective investigation results with corresponding dates: _____

_____

2. CURRENT PHYSICAL FUNCTIONAL IMPAIRMENTS

☐ Class 1 – capable of heavy occupational activities
☐ Class 2 – capable of moderate occupational activities
☐ Class 3 – capable of light occupational activities
☐ Class 4 – capable of sedentary occupational activities
☐ Class 5 – not capable of any type of gainful employment

Describe the specific effects of your patient's physical health condition(s) on his/her present ability to work: _____

_____

Task	No limitation	Limited Duration	Limited Frequency	Completely Limited	Reason/Limitation
Standing:	☐	☐	☐	☐	_____
Sitting:	☐	☐	☐	☐	_____
Walking:	☐	☐	☐	☐	_____
Lifting:	☐	☐	☐	☐	_____
Carrying:	☐	☐	☐	☐	_____
Squatting:	☐	☐	☐	☐	_____
Climbing:	☐	☐	☐	☐	_____
Pushing:	☐	☐	☐	☐	_____
Pulling:	☐	☐	☐	☐	_____
Driving:	☐	☐	☐	☐	_____

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN (CONTINUED)

Service Number (SN)

3. COMPETENCY

Is your patient competent to endorse cheques and direct use of the proceeds? Yes ☐ No ☐ If no, from what date? _____ (Day Month Year)

4. CURRENT PSYCHIATRIC FUNCTIONAL IMPAIRMENTS

- ☐ Class 1 – absent or minimal symptoms and essentially normal occupational functioning
- ☐ Class 2 – mild symptoms and occupational dysfunction
- ☐ Class 3 – moderate symptoms and occupational dysfunction
- ☐ Class 4 – severe symptoms and occupational dysfunction

Describe the specific effects of your patient's psychiatric condition(s) on his/her present ability to work:

_____

_____

_____

5. COMPLICATIONS

A) Please indicate any medical complications which are delaying your patient's recovery _____

_____

B) Other factors influencing illness (for example—work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional licence, etc.)

_____

C) Is there an alcohol or substance problem? No ☐ Yes ☐, please specify treatment centre and program details

_____

6. TREATMENT

A) Current medications. Please specify names of drugs, dosages, start dates and durations: _____

_____

_____

Response to treatment _____

_____

B) Other treatment (for example—physiotherapy, psychotherapy, counselling, day treatment programs). Please specify type, place, frequency and full name of facility: _____

_____

C) Dates Hospitalized (recent) Admission Date _____ (Day Month Year) Discharge Date _____ (Day Month Year)

Institution _____ Reason _____

D) Compliance: Is your patient following the recommended treatment program? Yes ☐ No ☐, please explain _____

_____

E) Please state frequency of visits: weekly ☐ monthly ☐ other ☐, please specify _____

_____

F) Please provide details of any proposed treatment plan including any recommended surgery _____

_____

G) Have you referred your patient to any other physician? No ☐ Yes ☐, please provide the full name and specialty _____

_____

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN (CONTINUED)

Service Number (SN)

7. MEDICAL FITNESS FOR VOCATIONAL REHABILITATION/RETURN TO WORK

A) In your opinion, is your patient medically fit to participate in a vocational rehabilitation program or return to work? Yes ☐ No ☐

B) If no, what supports do you think would be required to enable your patient to participate in a vocational rehabilitation program or return to work?

_____

_____

_____

_____

C) Has your patient expressed a desire to participate in a vocational rehabilitation program or return to work? Yes ☐ No ☐

Please comment: _____

_____

_____

_____

8. LICENCE RESTRICTION

Has your patient's professional licence certification, driver's or other licence been ☐ restricted, ☐ suspended, or ☐ revoked?

If yes, date _____ (Day Month Year) Specify the type of licence _____ Class of licence (if applicable) _____

9. ADDITIONAL INFORMATION

A) Remarks _____

_____

_____

B) Have you provided medical information on your patient's behalf for other benefits? ☐ No ☐ Yes If yes, please provide the full name of the company

_____

10. ATTENDING PHYSICIAN/SPECIALISTS

Current Attending Physician's name: (Please print or attach a business card)	Specialty
Address of Attending Physician	Telephone No. of Attending Physician
Current Specialist's name, if applicable: (Please print or attach a business card)	Specialty
Address of Specialist	Telephone No. of Specialist

11. ATTENDING PHYSICIAN'S DECLARATION AND SIGNATURE

I DECLARE that the information in this statement is true to the best of my knowledge.

_____ _____

Attending Physician's signature Day Month Year