Manulife

CLHIA ACCAP

Group Benefits
Attending Physician's Statement
Short Term Absence - Salary Continuance, Short Term Disability (STD) & Long Term Disability (LTD)

The purpose of this Statement is to assist Manulife in assessing your patient's fitness to perform their regular work duties.
Manulife recognizes and respects the role of the treating physician in the safe and timely return to work of their patients as outlined in the Canadian Medical Association Policy Statement.
To avoid any delay in the processing of your patient's case, please fax or mail the completed form to one of the following Manulife Case Management Centers (and keep a copy for your records).

Kitchener (English language)
Short Term Absence - Salary Continuance,
Short Term Disability & Long Term Disability
PO BOX 800 STN C
KITCHENER ON N2G 4Y5
Tel: 1-866-222-6268
Fax: 1-877-329-4431

Montreal (French language)
Short Term Absence - Salary Continuance,
Short Term Disability & Long Term Disability
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-866-222-6268
Fax: 1-866-744-5742

1 Employee information and consent (To be completed by patient.)

Employee name (last, first, middle initial)		Home phone number	Cell phone number
Address (number, street, apt.)	City	Province	Postal code
Name of employer **Air Canada**	Employee number	Policy numbers ☐ **Salary Continuance 0788027** ☐ **STD 0788026** ☐ **LTD 0788034**	
Height	Weight	Date of birth (dd/mmm/yyyy)	
Last date worked (dd/mmm/yyyy)		**Date returned to work or expected return to work date** (dd/mmm/yyyy)	

I hereby authorize the release of any medical information in my file to the Manufacturers Life Insurance Company ("Manulife") for the purpose of assessing this claim related to my fitness to perform regular work duties. The medical information includes, but is not limited to copies of all consultation reports, clinical notes, test results and hospital records. **I understand** that I can revoke this consent at any time but that without it, my claim cannot be assessed. **I understand that I am responsible for any fees related to the completion of this form. I agree** that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Employee signature ____________________ Date (dd/mmm/yyyy) ____________________

2 Attending physician's statement

STOP

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the last date worked, complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary:

Secondary:

If childbirth provide expected or actual delivery date (dd/mmm/yyyy) ____________________
Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☐

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)

Hospitalization

Is/was patient hospitalized ☐ or had day surgery ☐ Date admitted (dd/mmm/yyyy): ____________________

Name of institution: ____________________ Date discharged (dd/mmm/yyyy): ____________________

If surgery was performed provide date and description of surgery.

Date (dd/mmm/yyyy): ____________________ Description: ____________________

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☐ | If *yes*, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other ____________________

Attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) do not provide genetic test results**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist ____________________ Specialty ____________________ Date of visit ____________________

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

To your knowledge, is the patient following the recommended treatment program? Yes ☐ No ☐

Do you have concerns about the patient's ability to manage their own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life Insurance Company ("Manulife") and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending physician (please print)	Certified specialist		Physician's stamp
Address (number, street, suite)			
City	Province	Postal Code	
Telephone number	Fax number		
Signature	Date signed (dd/mmm/yyyy)		

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.