General Form

Attending Physician's Statement of Disability

RBC Insurance

WHAT WE REQUEST AND WHY

Your patient is applying for disability benefits under a policy of disability insurance underwritten by RBC Life Insurance Company.

As you can appreciate, the information provided by you is important to our adjudication of your patient's claim. We are asking for your cooperation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that the information, including the medical records requested, is required for the adjudication of your patient's claim and will be treated confidentially.

RBC Life Insurance Company is requesting copies of your complete file for the period of treatment for this condition, including specialist consultations, office notes, test results, hospital admission histories, discharge summaries and medical reports prepared for other insurers on your patient and is prepared to reimburse $50.00 for the costs associated with preparing the information. If this amount is unreasonable because of the extent of your patient's file, please have your staff contact our office at 416-643-4700 or toll free at 1 877-519-9501. **Any charge for the completion of this form, however, is the responsibility of the patient.**

We would like to thank you in advance for your cooperation.

Part 1: PATIENT INFORMATION

Name: Last _____ First _____ Middle _____

Address (Street / City / Province / Postal Code) _____ Telephone No: (_____) _____

Date of Birth (DD/MM/YYYY) _____ Policy No(s): _____

Claim No(s): _____

Part 2: DIAGNOSIS OF PRESENT CONDITION

Please attach copies of all consultation, operative and pathology reports.

Primary: _____

Additional conditions / complications: _____

Reported symptoms: _____

If diagnosis is pregnancy, give E.D.C.: _____ (DD/MM/YYYY)

Current Height: _____ Current Weight: _____ Weight loss/gain to date: _____

In your opinion when did the patient's condition first prevent him/her from working? _____ (DD/MM/YYYY)

CARDIAC (if applicable) **Please forward copies of exercise stress, angiogram, or other relevant documentation:**

a) Functional capacity (**Canadian Cardiovascular Society**, CCS):

☐ Class 1 (no limitation) ☐ Class 2 (mild impairment) ☐ Class 3 (moderate impairment) ☐ Class 4 (severe impairment)

b) Last three Blood Pressure Readings:

___ / ___ (Date: ___DD___MM____YYYY) ___ / ___ (Date: ___DD___MM____YYYY) ___ / ___ (Date: ___DD___MM____YYYY)
Reading Reading Reading

PSYCHIATRIC (if applicable) **Please indicate each Axis of DSM V DIAGNOSIS, using DSM-IV or DSM-5 Criteria. Please also describe the symptoms, severity and frequency and any medical or psychological tests that support each axis:**

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Please list symptoms that presently limit activity and function: _____

_____

_____

MENTAL STATUS EXAMINATION:

	DATE (DD/MM/YYYY)	NORMAL/ABNORMAL	DESCRIPTION
Appearance			
Behaviour			
Speech			
Affect			
Mood			
Cognition			
Insight			
Judgement			
Other			

Precipitating Events: _____

Work Issues: _____

Changes in Activities of Daily Living (ADLs) habits: _____

Are patient's symptoms due to drug or alcohol abuse? Yes ☐ No ☐

If "Yes", is patient enrolled in a substance abuse program? Yes ☐ No ☐

If "Yes", state facility: _____

Date of admission and discharge (if applicable): _____

Part 3: HISTORY AND FINDINGS

Date symptoms first appeared: _____ (DD/MM/YYYY)

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

If "Yes", please specify diagnosis and dates of treatment: _____

_____

Describe current symptoms: _____

First visit for these symptoms: _____ (DD/MM/YYYY)

Is the condition due to injury or sickness arising out of the patient's employment? Yes ☐ No ☐

If "Yes", has your office provided documentation in support of a claim for this condition with the WSIB, Workers'

Compensation Board/CSST on behalf of your patient? Yes ☐ No ☐

Have you filled out forms for an Auto Insurance carrier? Yes ☐ No ☐

If "Yes", please advise of name of carrier _____ Policy number _____

Please provide the names of other physicians who have been/will be involved in assessing the medical problems, **and copies of any available consultation reports:** _____

_____

Part 4: TREATMENT

Date of most recent treatment: _____ (DD/MM/YYYY)

Frequency of visits: Weekly ☐ Monthly ☐ Other ☐ If "Other", please specify: _____

Your patient was hospitalized as an in-patient: Yes ☐ No ☐

If "Yes", hospitalized at _____ from _____ to _____

Out-patient treatment: Yes ☐ No ☐

If "Yes", treated at _____ from _____ to _____

Treatment: Include information on all treatments to date and future treatment plan, including any surgical procedures:

_____

_____

Other: _____

Describe response to treatment to date: No Response ☐ Partial Response ☐ Complete Response ☐

Describe any complications that may prolong recovery (side effects secondary to treatment/other): _____

_____

Is patient following recommended treatment program? Yes ☐ No ☐ If "No", please explain: _____

_____

MEDICATIONS:

Name of Medication	Date Started (DD/MM/YYYY)	Initial Dosage	Initial Response	Side Effects	Date Dosage Last Changed (DD/MM/YYYY)	Date Medication Discontinued (DD/MM/YYYY)

What is your prognosis?

☐ Recovery without impairment (loss of function) Number of weeks _____

☐ Stabilization with continuing impairment Number of weeks _____

☐ Stabilization of unknown duration

☐ Permanent impairment

Comments: _____

_____

Part 5: FUNCTIONAL ABILITIES

Please indicate your patient's current physical abilities:

☐ **Sedentary Duties:** Exerting up to 10 pounds (4.5 kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary Duties involve sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Duties:** Exerting up to 20 pounds (9.1 kg) of force occasionally and/or up to 10 pounds (4.5kg) of force frequently, and/or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Duties. Light Duties usually require walking or standing to a significant degree. However, if the use of the arm and/or leg controls require exertion of forces greater than that for Sedentary Duties and the worker sits most of the time, the job is rated Light Duties.

☐ **Medium Duties:** Exerting up to 50 pounds (22.7 kg) of force occasionally and/or up to 25 pounds (11.3kg) of force frequently, and/or up to 10 pounds (4.5 kg) of force constantly to move objects.

☐ **Heavy Duties:** Exerting up to 100 pounds (45.4 kg) of force occasionally and/or up to 50 pounds (22.7 kg) of force frequently, and/or up to 20 pounds (9.1 kg) of force constantly to move objects.

☐ **Very Heavy Duties:** Exerting in excess of 100 pounds (45.4 kg) of force occasionally and/or up to 50 pounds (22.7 kg) of force frequently, and/or up to 20 pounds (9.1 kg) of force constantly to move objects.

What are the obstacles that are preventing a return to employment, if any? _____

_____

In your opinion, what is the earliest date your patient will be able to return to work? _____ (DD/MM/YYYY)

If the previous job could be modified, when could rehabilitative employment commence? _____ (DD/MM/YYYY)

Driver's license revoked: Yes ☐ No ☐ If "Yes", please provide date: _____ (DD/MM/YYYY)

Part 6: COMPETENCY

Do you believe your patient is competent to endorse cheques and direct the use of the proceeds thereof? Yes ☐ No ☐

If "No", from what date? _____ (DD/MM/YYYY)

If "No", have you referred the case to the Public Trustee, or has a Guardian been appointed, or is there a Power of Attorney?

Yes ☐ No ☐

Part 7: COMMENTS

We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

_____

_____

SIGNATURE

X _____ _____

Signature | Date (DD/MM/YYYY)

_____ _____

Physician's Name (Please print) | Degree and Specialty

☐ Primary Care ☐ Consultant

_____

Address (Street / City / Province / Postal Code)

Email Address: _____

Telephone No: (_____) _____ Fax No: (_____) _____

Send the completed form and documents to our office by email: intake@rbc.com

You can also fax the information to: RBC Life Insurance Company, Life and Health Claims Department, 1-800-714-8861.

If you have any questions, call toll free 1-877-519-9501 or 416-643-4700.
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www.rbcinsurance.com