



- LONG TERM DISABILITY (LTD) BENEFITS
- CONTINUATION OF BENEFITS DURING DISABILITY (WAIVER OF PREMIUM)

Instructions:

1. Please print
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.

Please note:

The patient is responsible for the securing of this form and any charge for its completion.

PART 1 - PATIENT AUTHORIZATION

Name: _____ Age: _____
(First) (Last)

Social Insurance Number: _____ - _____ - _____ Tel. No.: _____

I hereby authorize the attending/consulting physician and/or health institution/provider to release any information in respect of this claim to my benefits' adjudicators and/or policyholder. I understand that any charges for having this form completed are my responsibility.

Signature: _____ Date _____

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis

Primary: _____ Symptoms _____

Secondary: _____ Symptoms _____

Other contributing factors/complications: _____

2. History

Symptoms began or accident happened on:

D	M	Y

Date of first visit for current condition:

D	M	Y

Work ceased due to illness or injury on:

D	M	Y

Is this a work-related illness/injury? Yes No Unknown

Has patient ever had same or similar condition? Yes No If yes, state when and provide details:

Relevant medical history? Please explain and give approximate dates. _____

If condition is related to pregnancy, indicate date or expected date of delivery:

D	M	Y

3. Clinical Findings/Investigations

Date of most recent examination of patient:

D	M	Y

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Cardiac: _____ Class 1 no limitation Class 2 slight limitation Class 3 marked limitation Class 4 complete limitation
 (if applicable)

➔ ATTACH ALL COPIES OF CURRENT X-RAYS, EKGS, LABORATORY DATA, CONSULTATION REPORTS, HOSPITAL DISCHARGE SUMMARIES, CLINICAL NOTES ETC.

Any other investigations planned? Yes No If yes, state when and type of investigation _____

Is patient being treated or referred to other physician(s)/specialist(s)? Yes No If yes, please complete the following:

Physician's Name & Specialty	Date Patient last seen and next date to be seen

4. General Impression (Describe appearance, development, nutrition, posture, gait, distress, mental alertness, apparent age, etc.)

5. Treatment - Frequency of patient visits: _____ Date of last visit:

D	M	Y

Medications? Yes No If yes, please provide details below.

Current medications	Dosage

Surgery? Yes No If yes, please provide details below.

Type of Surgery	Date Performed or Date Planned

Hospitalization? Yes No If yes, please provide details below.

Admission Date	Discharge Date	Facility	Reason

Therapy? Yes No If yes, please provide details below.

Type (e.g. physio, psycho, chiro)	Name of Practitioner

Is the patient receiving or in need of treatment for the use of alcohol or drugs? Yes No

Any other treatment or future plans for treatment? (Please specify with dates.) _____

Summarize patient's response to treatment:

Is patient following recommended treatment? Yes No (Please elaborate.) _____

6. Functional Capability - If condition is psychiatric, provide multi-axial assessment, if available.

Is patient: ambulatory house confined bed confined hospital

confined? Please check box that best describes patient's level of function:

- No limitation of functional capacity; capable of normal activity.
- Minimal limitation of functional capacity; capable of moderate activity.
- Medium limitation of functional capacity; capable of light activity.
- Severe limitation of functional capacity; incapable of minimal activity.

Please provide details of any functional limitations/restrictions and provide examples of activity patient is capable of doing:

7. Prognosis & Recovery Factors

Prognosis and timeframe for medical recovery: _____

Other factors affecting recovery? Please explain. _____

Please indicate factors to be considered regarding a return to work plan: _____

8. Remarks

Please provide any additional information or details that may be helpful. _____

Name of Attending Physician _____

(Please print)

Address: _____ Tel.No. () _____ - _____

_____ Fax No. () _____ - _____

Signature: _____ Date: _____

Complete and return to: Vestcor Pension Services Corporation (VPSC)
P.O. Box 6000, Fredericton, NB E3B 5H1
Telephone: (506) 453-2296 Toll Free in Canada: 1-800-561-4012 Fax: (506) 457-7388
