THE Great-West Life ASSURANCE COMPANY

GROUP LIFE INSURANCE
WAIVER OF PREMIUM APPLICATION
INITIAL ATTENDING PHYSICIAN'S STATEMENT

PART B

Patient Authorization

Name: _____ Group Plan Number: **330780**

Employee Number: _____

Address: _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Date: _____ Signature of Patient: _____

Attending Physician's Initial Statement

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion. Upon completion, please return to your patient.

1. **History**

   Date symptoms first appeared or accident happened. Year_____ Month _____ Day _____

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

   If yes, please specify diagnosis and dates of treatment _____

   _____

2. **Diagnosis** (including any complications)

   Primary _____

   Secondary _____

   Subjective Symptoms: _____

   Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

   _____

   _____

3. Current Height _____ Current Weight _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year_____ Month _____ Day _____

5. **Treatment**

   What is the current treatment regimen? (drug dosage, physio, other and progress)

   _____

   _____

   Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Clear

6. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No
   If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

7. Please indicate your patient's current physical abilities:

   ☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

   ☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

   ☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

   ☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

   List physical restrictions and tolerances: _____

   In your opinion, what is the earliest date your patient will be able to return to work?

   Year _____ Month _____ Day _____

   If the previous job could be modified, when could rehabilitation employment commence?

   Year _____ Month _____ Day _____

8. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

   _____

   _____

9. **Hospitalization** if applicable for this illness or injury

   Date of in-patient admission: Year _____ Month _____ Day _____

   Date of discharge: Year _____ Month _____ Day _____

   Date of out-patient treatment: Year _____ Month _____ Day _____

   Name of hospital: _____

10. **Surgery**

    Surgical procedure performed: _____

    Date of surgery: Year _____ Month _____ Day _____

    Name of surgeon: _____

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

    _____

    _____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____