



## INITIAL CLAIM FORM FOR DISABILITY BENEFITS

### PART 1 - AUTHORIZATION TO BE COMPLETED BY MEMBER

**AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION** - I authorize any Physician, Hospital, Insurer, Employer or any other organization or person having any records, data or information concerning me to furnish such records, data or information as may be requested by CUMIS Life Insurance Company.

I understand that the personal information furnished herein will be used by CUMIS to administer my claim, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
SIGNATURE OF MEMBER

\_\_\_\_\_  
AREA CODE - TELEPHONE NO.

\_\_\_\_\_  
MONTH / DAY / YEAR

### PART 2 - STATEMENT TO BE COMPLETED BY ATTENDING PHYSICIAN

**NOTE TO PHYSICIANS** - Time is a precious commodity and in the interest of time, this form has been designed to obtain comprehensive information relating to your patient's medical history, investigation, findings and treatment. By obtaining detailed information now, it is our intention to reduce your paperwork and, wherever possible, avoid requests for additional medical information.

The information furnished herein will be used by CUMIS for claims administration purposes, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

Other than where prohibited by law, your patient is responsible for any charges incurred in connection with the completion of this form.

CLAIM NO. \_\_\_\_\_

1. Patient's Name (Mr., Mrs., Miss, Ms.) \_\_\_\_\_  
Last Initial First

2. Are you the Family Physician?  Yes - How long? \_\_\_\_\_  No - Name of Family Physician \_\_\_\_\_

3. a. Primary diagnosis \_\_\_\_\_

Objective findings \_\_\_\_\_  
(Please include interpretive results of any investigation performed)

Subjective symptoms \_\_\_\_\_

b. Secondary diagnosis \_\_\_\_\_

c. Describe complications or independent conditions such as surgery which may prolong the disability.  
 \_\_\_\_\_

d. Current functional limitations \_\_\_\_\_  
 \_\_\_\_\_

**4. NOTE: If dates are indicated, please answer**

Has this patient received any medical advice, consultation or treatment for any sickness, disease or bodily injury directly or indirectly related to his/her primary disability?

From \_\_\_\_\_ To \_\_\_\_\_ Yes  No

If "Yes", please give all dates and types of treatment during this period  
 \_\_\_\_\_

5. a. When did symptoms first appear or accident happen? month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

b. When did patient first consult you for this condition? month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

c. What date did your patient stop working due to disability? month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

d. Was patient referred from a prior physician? Yes  No  If "Yes", give name and address

6. Is condition due to:

a. Pregnancy? Yes  No  If "Yes", give expected date of delivery? month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

b. Childbirth, abortion or miscarriage? Yes  No

- c. The commission or attempted commission of a criminal offense? Yes  No
- d. Alcohol, drugs or drug related? Yes  No  If "Yes", what substance? \_\_\_\_\_
- e. Work related? Yes  No  If "Yes", details \_\_\_\_\_

7. a. Have you been actively supervising this patient's care?  
 Yes Frequency of visits: Weekly  Monthly  Other \_\_\_\_\_  
Specify  
 No (Please comment in REMARKS)

b. Is patient following recommended treatment program? Yes  No  (Please comment in REMARKS)

c. Date of last treatment month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

d. Type of treatment, medication, therapy, etc. your patient is presently receiving \_\_\_\_\_  
 \_\_\_\_\_

e. Date of hospital in-patient admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_  
month / day / year month / day / year

Name of hospital \_\_\_\_\_

8. Is the patient still totally disabled? (Unable to perform most of the duties of his/her regular occupation.)  
 Yes Do you feel patient will be disabled longer than 4 months from the present date? Yes  No

Please provide date the patient will be able to resume his/her regular occupation. \_\_\_\_\_  
month / day / year

No If "NO" provide date when patient was or will be capable of resuming his/her regular occupation. \_\_\_\_\_  
month / day / year

9. Has the patient been referred to any other physicians, clinics, physiotherapists, etc.?

Yes If "YES", please provide names and addresses in REMARKS.  
 No

**PAST MEDICAL HISTORY**

10. Has patient been seen during the past 5 years for any of the following (Please summarize any "YES" answers below)

	YES	NO		YES	NO		YES	NO		YES	NO
Cardiovascular/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory/Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal EKG's or Laboratory Tests	<input type="checkbox"/>	<input type="checkbox"/>	Gastro-Intestinal	<input type="checkbox"/>	<input type="checkbox"/>	Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>				Genito-Urinary	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Immunological (including AIDS Antibody)	<input type="checkbox"/>	<input type="checkbox"/>				Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Family History	<input type="checkbox"/>	<input type="checkbox"/>

DATES ATTENDED			COMPLAINTS & ABNORMAL PHYSICAL FINDINGS	DURATION OF ILLNESS	DIAGNOSIS	DESCRIBE TREATMENT MEDICATIONS or OPERATION
MONTH	DAY	YEAR				

**REMARKS** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. Name of Attending Physician (PLEASE PRINT) \_\_\_\_\_

Street Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
Number Street City Province Postal Code Area Code

FAX No. \_\_\_\_\_  
Area Code

Date \_\_\_\_\_ SIGNATURE OF ATTENDING PHYSICIAN \_\_\_\_\_  
Month / Day / Year