



SUPPLEMENTAL DISABILITY CLAIM FORM

PART 1: STATEMENT AND AUTHORIZATION TO BE COMPLETED BY THE INSURED

CLAIM NO. _____

1. Name of Claimant (please print) _____
Last First Middle (area code) Phone Number

2. Mailing Address _____
Street City Province Postal Code

3. **a.** What medical attendance have you received since your last report? Treatment Prescribed (e.g., Physiotherapy, X-rays,
Name and Address(es) of Doctor(s) Date(s) Attended other tests, drugs and dosages).

- b.** Describe any changes in your condition (improvement or deterioration) since last report.

4. Are you presently, or were you confined, to hospital? YES NO
If "YES", please provide:
a. Name of Hospital _____
b. Dates confined: From: month ____ day ____ year ____ To: month ____ day ____ year ____
c. Reason for admission, treatment provided _____

5. Are you presently confined to home? YES NO
If "YES", please explain _____

6. What was the date you last worked before you became disabled? month ____ day ____ year ____
7. Are you still disabled from most of the duties of your regular occupation? YES NO
8. If "NO", on what date did you return to work? month ____ day ____ year ____ Full-Time Part-Time # of hours per day ____
 # of hours per week ____
9. Are you capable of "light duty" employment? YES NO If "YES", are you employed in a light duty job? YES NO
If "YES", **a.** as of what date: month ____ day ____ year ____ **b.** duties performed _____
c. name of employer _____ **d.** number of hours worked per day _____
e. number of days worked per week ____ **f.** date you anticipate returning to full employment: month ____ day ____ year ____
10. What is the approximate balance of your loan? _____
11. Are you receiving accident or sickness benefits from any other source? YES NO
If "YES", please provide the name of the source and the monthly benefit amount:
Source _____ Monthly Benefit Amount _____

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 the 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.

I certify that the answers given on this form are complete and correct to the best of my knowledge.

Dated this ____ day of _____, year ____ Claimant Sign Here _____

PART 2 - SUPPLEMENTAL STATEMENT TO BE COMPLETED BY ATTENDING PHYSICIAN

CLAIM # _____

- 1. Patient's Name _____
 - 2. Diagnosis of present condition and initial date of onset: month ____ day ____ year ____
 - a. Primary _____
 - b. Secondary (if applicable) and initial date of onset: month ____ day ____ year ____
 - c. Current functional limitations _____
 - 3. a. Indicate complications or new independent conditions which may prolong the disability _____
 - b. Has surgery been contemplated or performed? YES NO
 If "YES", please advise type _____ and date: month ____ day ____ year ____
 - 4. Date of last attendance: month ____ day ____ year ____
 - 5. a. Have you been actively supervising this patient's care? YES NO If "NO" comment in REMARKS
 YES - Frequency of visits: Weekly Monthly Other (specify) _____
 - b. Is patient following recommended treatment program? YES NO If "NO" comment in REMARKS
 - c. Please provide dates and type of treatment received within the last 3 to 6 months _____
6. Is the patient still totally disabled? (unable to perform most of the duties of their 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 Full-time _____ Part-time _____
month/day/year month/day/year
- Please provide date the patient will be able to resume alternate employment Full-time _____ Part-time _____
month/day/year month/day/year
- NO If "NO" provide date when patient was or will be capable of resuming his/her regular occupation _____
month/day/year
7. Is patient a suitable candidate for a rehabilitation and/or retraining program for alternate employment? YES NO
- a. If "YES", on what date could such a program commence? month ____ day ____ year ____
 - b. If such a program has commenced, when did it start? month ____ day ____ year ____
 - c. If "NO", kindly elaborate _____

Complete this section if disability is due to CARDIAC CONDITION

- 8. a. Functional capacity (American Heart Ass'n) Class 1 (No limitation) Class 2 (Slight limitation)
- b. Blood pressure _____ Class 3 (Marked limitation) Class 4 (Complete limitation)
(Representative readings and dates over last 3 visits)

REMARKS _____

Physician's Name (Print) _____ Address _____

Telephone No. (area code) _____ Signature _____ Date _____

FAX No. (area code) _____

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, THE PATIENT IS RESPONSIBLE FOR ANY CHARGES INCURRED IN COMPLETION OF THIS FORM.