CUMIS Life Insurance Company
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CUMIS®

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 ☐

CLAIM # _____

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 _____ month / day / year Date of Discharge _____ 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		☐	Psychiatric		☐	Alcohol/Drug Abuse		☐	Respiratory/Allergy		
Endocrine		☐	Abnormal EKG's or Laboratory Tests			Gastro-Intestinal		☐	Musculo-Skeletal		
Cancer						Genito-Urinary		☐	Other		
Immunological *(including AIDS Antibody)*	☐					Neurological		☐	Family History		

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

REMARKS _____

_____

_____

11. Name of Attending Physician (PLEASE PRINT) _____

Street Address _____ *Number Street City Province Postal Code*

Phone No. _____ *Area Code*

FAX No. _____ *Area Code*

Date _____ Month / Day / Year SIGNATURE OF ATTENDING PHYSICIAN _____