NATIONAL BANK
INSURANCE

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PHYSICAL ILLNESSES

DISABILITY INSURANCE
Physician's statement

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For psychological illnesses, please complete the form specific to that purpose (F.29550-502).

IDENTIFICATION OF THE INSURED

First name ____________ Last name ____________ Date of birth (YYYY MM DD) ____________ Gender: ☐ M ☐ F

PHYSICIAN'S STATEMENT

In order for us to properly assess the insured's claim, please answer all questions in as much detail as possible.

A. GENERAL INFORMATION

1. Are you the family physician? ☐ No ☐ Yes
   a) If so, how long have you been this person's physician (YYYY MM DD): ____________
   b) If not, provide the name and contact information of the family physician:

2. To the best of your knowledge, does the patient **currently** use tobacco or marijuana, or a nicotine replacement product in any form whatsoever? ☐ No ☐ Yes ☐ Don't know

   If so:

   a) Indicate the type of substance and quantity consumed per day: ____________
   b) How long has the patient been using this substance on a continuous basis (YYYY MM DD)? ____________
   c) To the best of your knowledge, has the patient ever stopped using these substances for periods of time (from what date to what date)?

   If not:

   d) To the best of your knowledge, has the patient **ever used** tobacco or marijuana, or a nicotine replacement product in any form whatsoever? ☐ No ☐ Yes ☐ Don't know
   e) If so, specify the period(s) (from what date to what date) when he/she used these substances:

   f) Indicate the type of substance and quantity consumed per day: ____________
   g) When did the patient stop using this substance (YYYY MM DD)? ____________

3. To the best of your knowledge, over the last three (3) years, has the patient used any unprescribed narcotics or medication?
   ☐ No ☐ Yes ☐ Dont' know
4. To the best of your knowledge, over the last (3) three years, has the patient received treatment or joined an organization because of his/her alcohol consumption, or has a health professional advised him/her to reduce his/her alcohol consumption?
   ☐ No ☐ Yes ☐ Dont' know

B. DIAGNOSIS

5. Primary diagnosis: ____________
6. Secondary diagnosis: ____________
7. Are there any complications that could extend the period of disability? ☐ No ☐ Yes
   a) If so, provide details:

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

a) If so, indicate when (YYYY MM DD) and describe the condition in detail and treatment received:

9. Is the condition related to: ☐ An illness

☐ A pregnancy ☐ Preventive leave Expected date of confinement (YYYY MM DD):

☐ An accident/work accident Date of the event (YYYY MM DD):

Location where the accident occurred:

10. Did or will the patient have an X-ray, MRI or any other tests? ☐ No ☐ Yes

a) Specify the dates:

11. List the patient's symptoms (including the severity and frequency) and specify which ones you personally observed:

12. When did these symptoms first appear (YYYY MM DD)?

13. What are the patient's current limitations that you have observed (**actions he/she cannot perform**)?

14. What are the current limitations with which the patient must cope (**actions he/she should not perform**)?

C. TREATMENT

15. Medication, dosage and date prescribed:

16. Did or will the patient undergo surgery? ☐ No ☐ Yes

a) If so, specify the nature and date of the intervention (YYYY MM DD):

17. Has the patient been hospitalized for this condition? ☐ No ☐ Yes

Specify:

Date admitted (YYYY MM DD) Date discharged (YYYY MM DD)

Name of the hospital Address of the hospital (No., street, city, province, postal code)

18. Other treatments (physiotherapy, occupational therapy, massage therapy, chemotherapy, etc.):

19. Is the patient following the recommended treatment plan? ☐ No ☐ Yes

a) If not, provide details:

D. FOLLOW-UP AND PROGNOSIS

20. Date the patient stopped working because of his/her illness or injury (YYYY MM DD):

21. Did the patient consult you on this date? ☐ No ☐ Yes

a) If not, provide the name and contact information of the physician the patient consulted on the date of his/her work stoppage:

b) When did he/she consult you for the first time (YYYY MM DD)?

22. Dates of consultations: ______________________

a) Frequency of consultations: ______________ Next consultation: ______________

23. Was the patient referred to another physician? ☐ No ☐ Yes

a) Name of physician and specialty: ______________________

b) If not, explain:

24. If you anticipate that the absence from work will exceed the usual period for such a diagnosis, specify the factors that justify your prognosis:

25. Approximate duration of incapacity: ______________ or ______________ or ______________

No. of weeks — No. of months — Scheduled date of return to work (YYYY MM DD)

E. MEDICAL HISTORY

26. Over the past five years, has the patient consulted or been treated by a health professional, had a medical exam or follow-up, suffered from or been diagnosed with one of the following health issues: cardiac or blood vessel disorder, blood disorders including high cholesterol, high or low blood pressure, tumours or cancer, muscular dystrophy, multiple sclerosis, AIDS, HIV or any other immunological disorder, chest pains or angina, lung or respiratory problems, digestive problems, liver problems, intestinal problems, kidney problems, urinary tract problems, problems with reproductive organs, disorders of the nervous system, diabetes, fibromyalgia or chronic fatigue, back, neck or spinal column problems, problems with muscles, joints or bones, or psychological or psychiatric problems.

☐ No ☐ Yes ☐ Don't know

Illnesses	Date (YYYY MM DD)	Results/Treatment	Periods of hospitalization	When was the patient informed of the diagnosis?

Additional comments:

DOCUMENTS REQUIRED

Submit a copy of all medical examinations (laboratory results, pathology reports, X-rays, nuclear imaging) and consultation reports (yours and those of specialists) and any other document related to the disability claim.

PHYSICIANS IDENTIFICATION

27. ______________________

First and last name

28. ______________ ☐ General practitioner ☐ Specialist, specify: ______________

Licence No.

29. ______________________

Address (No., street, city, province, postal code)

______________ ______________

Telephone No. — Fax No.

______________ ______________

Date (YYYY MM DD) — Signature

NOTE: The insured must pay any fees charged to complete this form.