



Long Term Disability Claim

An incomplete form may result in delays in the adjudication of your disability claim.

Once completed, please send the claim form to:

Executive Director

Pension Office Corporation
175 Bloor St East,
South Tower Unit 1201
Toronto ON M4W 3R8

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your employer and your physician(s).

We ask you to provide information about what you are capable and incapable of doing, in relation to your job demands.

We ask your employer to tell us about your job demands.

We ask your physicians to provide us with information about your restrictions and limitations.

You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.

All of the above information will be reviewed to determine whether you meet the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Important notice

The Pension Office Corporation of The Anglican Church of Canada is responsible for the administration of long term disability (LTD) claims. The Pension Office has partnered with Workplace Health and Cost Solutions Ltd. (operating as Oncidium) to assess and manage long-term disability (LTD) claims during the first 22 months of disability. The Pension Office Corporation has also engaged Manulife to provide disability coverage and manage claims where a member remains disabled beyond 22 months, at which time the LTD claim would be transitioned to Manulife.

How this claim will be assessed and managed

- For the first 22 months that a plan member is considered disabled, Oncidium assesses and manages the claim and any payments are the responsibility of The Pension Office Corporation.
 - If the plan member continues to be disabled beyond 22 months, Manulife will then become the disability insurer and take over management of the claim. While Manulife, The Pension Office and Oncidium work in partnership throughout a disability, the transition of the claim to Manulife will start approximately 2 months prior to the expected transition date to ensure the seamless transition of the claim. Only if the disability extends beyond 22 months will Manulife be responsible as disability insurer.
 - The goal of the claim management process is to ensure that claims are assessed in a timely manner and that those plan members who possess the potential to return to work receive support and assistance in returning to part-time or full-time employment.
 - By working together, the number of forms that plan members need to complete is reduced. For example, this form is the only initial disability claim form a plan member needs to complete. Those plan members who will transition to Manulife will not need to complete another form specifically for this transition. Oncidium will simply transfer the information they have to Manulife at the appropriate time.
 - In order to ensure confidentiality of personal information, The Pension Office Corporation and Oncidium (and as applicable Manulife) will each establish a disability claim file in which information concerning all of your disability claims will be kept. Only employees or authorized agents of The Pension Office Corporation, Oncidium or Manulife who are responsible for the management of your claim shall have access to the files.
 - Plan members can be confident that whether they are dealing with The Pension Office, Oncidium or Manulife, experienced disability professionals and administrators will provide superior service and expert claims management on each and every claim submitted to The Anglican Church of Canada LTD Plan.
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Instructions

1. Please complete the "Plan Member Statement" section.
 2. Please ensure that the Employer completes the "Employer Statement" section.
 3. Please ensure that your physician completes the "Attending Physician's Statement". Please ensure that you complete the Patient Authorization section of the "Attending Physician's Statement" prior to providing it to your physician.
 4. Please note that any costs incurred in the completion of the "Attending Physician's Statement" are your responsibility.
 5. Please ensure that all of the above-mentioned forms are submitted on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.
 6. Please note that Long Term Disability (LTD) benefits are reduced by certain benefit payments including those made by CPP/QPP (disability) and Worker's Compensation. It is the responsibility of the employee to repay any overpayments that occur as a result of eligibility for these types of benefits for periods in which LTD was also paid.
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Group Benefits Plan Member Statement Long Term Disability Claim

Executive Director
Pension Office Corporation
175 Bloor St East,
South Tower Unit 1201
Toronto ON M4W 3R8

Additional information may be submitted on separate pages if there is insufficient space on this form.

1 Plan member information

You can obtain your plan number, division number, and your plan member certificate number from your benefit card.

Plan contract number 5640		Plan sponsor's name The Anglican Church of Canada	
Division number	Plan member certificate number	Job title	
SIN	Date of birth (dd/mmm/yyyy)		
Full name (last, first, initial)			
Street address (number, street and apartment)			
City		Province	Postal code
Phone number	Fax number	Height	Weight
Mailing address (if different from above)			

2 Work information

- a) Last day worked?
- b) Prior to stopping work had your job been modified?

(dd/mmm/yyyy)

Yes No *If yes, how was it modified?*

- c) If your work was modified, why were you unable to continue working?

- d) How long were you performing modified work?

- e) Since work absence commenced:

Have you done any work for pay? <input type="radio"/> Yes <input type="radio"/> No	Dates (dd/mmm/yyyy) (from - to)	Describe
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3 Other activities information

Since work absence commenced:

Have you returned to school/retraining? <input type="radio"/> Yes <input type="radio"/> No	Dates (dd/mmm/yyyy)	Describe
Have you done volunteer activity? <input type="radio"/> Yes <input type="radio"/> No	Dates (dd/mmm/yyyy)	Describe

4 Injury information

- a) Is work absence due to an injury?
b) What kind of injury?
c) Describe how and when injury occurred.

Yes No *If no, please go to section 6, Illness information.*

Motor vehicle accident Work related Other _____

- d) Is there any legal action involved?

Date of injury (dd/mmm/yyyy) Time of injury am pm

Yes No *If yes, please provide lawyer's name and address.*

Lawyer's name _____ Lawyer's address _____

Phone number _____

- e) Was the occurrence investigated by police?

Yes No *If yes, please provide a copy of the police report.*

5 Motor vehicle accident information

- a) If your work absence is related to a motor vehicle accident, please provide the following information:

Your insurer's name _____ Your insurance adjuster's name and phone number _____

Your insurance policy number or claim number _____

6 Illness information

- a) Have you ever had the same or a similar illness?
b) Did the illness result in an absence from work?
c) Describe your current condition, including how it prevents you from working.

Yes No *If yes, state when and describe.*

Yes No *If yes, state when.*

From (dd/mmm/yyyy) _____ To (dd/mmm/yyyy) _____

7 Medical information

a) Please provide the following information about the family doctor who has your MEDICAL RECORDS.

Last name of doctor		First name of doctor		Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite		Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City		Province		Frequency of visits	
Postal code	Telephone number		Type of practitioner		

b) Please provide the following information about ANY OTHER SPECIALIST OR HEALTH CARE PRACTITIONER you have seen or are scheduled to see for this condition. (e.g. chiropractor, physiotherapist, psychologist, etc.)

Last name		First name		Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite		Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City		Province		Frequency of visits	
Postal code	Telephone number		Type of practitioner		

Last name		First name		Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite		Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City		Province		Frequency of visits	
Postal code	Telephone number		Type of practitioner		

Last name		First name		Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite		Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City		Province		Frequency of visits	
Postal code	Telephone number		Type of practitioner		

Last name		First name		Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite		Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City		Province		Frequency of visits	
Postal code	Telephone number		Type of practitioner		

8 Income/Benefit information

Have you received or are you receiving any of the following income/benefits.

If so, please provide copies of pay slips and/or award letters, including decline letters.

Receipt of any benefits, including the following may result in a reduction to the benefit you receive under the Long Term Disability Plan (LTD Plan) and may require reimbursement to the LTD Plan through The Pension Office and/or to Manulife of any benefit paid under this claim. It is imperative that you notify us of any change in the status of these benefits.

INCOME/BENEFIT	DATE OF APPLICATION (dd/mmm/yyyy)	REFERENCE OR CLAIM NUMBER	CURRENT STATUS: (Check all that apply)				
			PENDING?	AWARDED?	DECLINED?	TERMINATED?	APPEALED?
QPP			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CPP			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Workers' compensation*			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other group insurance			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Association plan			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motor vehicle insurance			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salary continuation			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any short term plan			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment insurance			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Retirement - government			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severance			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and de l'équité, de la santé et de la sécurité du travail (CNESST).

9 Summary of education, training and experience

Please attach a copy of a current résumé, if available. Otherwise, please provide the following information.

a) Education

SCHOOL	LOCATION	LEVEL OBTAINED	YEAR	AREA OF STUDY
Elementary school/ High school				
College or university				
Other (Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.)				

b) Work experience

Begin with most recent but include every job you have had in the last 15 years. If more space is required, please use additional sheets of paper.

DURATION OF EMPLOYMENT		EMPLOYER	JOB TITLE AND DUTIES
FROM	TO		

9 Summary of education, training and experience (continued)

c) Acquired skills

If not already mentioned in the education section, these may include typing, operation of equipment, supervisory skills, special licenses or designations, etc. Where appropriate, give level, speed or proficiency.

10 Driver's licence information

a) Does your job require you to have a professional licence or designation? Please explain.

Yes No

b) Do you have a valid driver's licence?

Class	Indicate any restrictions
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11 Other interests

Hobbies and interests, including any volunteer work.

12 Work capacity evaluation

In this section we are gathering information about your job duties and your ability or inability to do them. Please indicate the extent that you are now able to perform each activity that your job requires. If you have indicated "UNABLE TO DO", please provide primary reason.

PHYSICAL ACTIVITIES	Activity	N/A	SELDOM (<small>< 1 hr.</small>)	INFREQUENT (<small>1 - 2 hrs.</small>)	OCCASIONAL (<small>2 - 4 hrs.</small>)	FREQUENT (<small>4 - 6 hrs.</small>)	CONSTANT (<small>> 6 hrs.</small>)	UNABLE TO DO (<small>Please explain</small>)
	Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kneeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending/Squatting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crouching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crawling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation; fingers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Simple grasping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation; hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repetitive body motions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - at shoulder level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - below shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - side to side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - up and down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Activity	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY		
Lifting - floor to waist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Lifting - waist to shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Lifting - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Carrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant

PHYSICAL	Are you able to work in any of the following conditions?	Yes	No	If no, please explain
	Exposure to marked changes in temperatures and humidity	<input type="radio"/>	<input type="radio"/>	
	Being around moving machinery	<input type="radio"/>	<input type="radio"/>	
	Unprotected heights	<input type="radio"/>	<input type="radio"/>	
	Exposure to dust, fumes and gases	<input type="radio"/>	<input type="radio"/>	
	Driving automobile equipment	<input type="radio"/>	<input type="radio"/>	

In this section we are gathering information about your job duties and your ability or inability to do them. For each activity that your job requires of you, please indicate the extent to which you are able to do it. If you have indicated "UNABLE TO DO", please provide primary reason.

PSYCHOLOGICAL ACTIVITIES	A. Understanding and memory	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Remember locations and routine procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	B. Sustained concentration and persistence	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Carry out short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Carry out detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Maintain attention and concentration for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Perform activities within a schedule	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Sustain an ordinary routine without supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Make simple decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Solve simple straightforward problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Solve complex problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	C. Social interaction	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Interact with the general public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Ask questions or request assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Accept instructions and feedback	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Get along well with others without distracting them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Get along well with others without being distracted by them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	D. Adaptation	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Respond to frequent changes in the environment or tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Aware of normal hazards and take appropriate precautions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Travel in unfamiliar places or use public transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Set realistic goals or make plans independently of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Juggle tasks and prioritize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
E. Responsibility and accountability					Yes	No		
Is work pace without the pressure of deadlines?					<input type="radio"/>	<input type="radio"/>		
Does the work involve occasional pressure to meet deadlines?					<input type="radio"/>	<input type="radio"/>		
Does the work involve periodic pressure to meet deadlines?					<input type="radio"/>	<input type="radio"/>		
Does the work involve significant pressures?					<input type="radio"/>	<input type="radio"/>		

13 Other information

Please provide any additional information that you believe should be considered in assessing your claim.



Group Benefits Plan Member Statement Agreement, authorization and certification

14 Agreement, authorization and certification

I confirm that:

- I have read and understood the notice on page 1 of this claim form that explains the claim assessment and management process.
- The information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- My claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) will investigate my claim(s) and will require personal information about me, which may include information regarding my activities, income, employment, education, training, health, and medical history and treatment, including clinical notes.
- I will participate and cooperate with the disability management process and remain available for work and will perform modified work, as I am medically able.
- A photocopy or electronic version of this authorization shall be as valid as the original.
- I understand that more specific details regarding how and why The Pension Office Corporation, Oncidium and Manulife collect, use, maintain, and disclose my personal information can be found in their respective privacy policies, available on their websites or at www.anglicanpension.ca, www.oncidium.com and www.manulife.ca respectively.

I authorize:

- The Pension Office Corporation and Oncidium (and as applicable Manulife) and their respective service providers, any person or organization who has personal information about me, including any employer, group plan administrator, plan sponsor, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer and administrator of government benefits or other benefits programs, to exchange my personal information with each other for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claims, including independent medical assessments.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) and their reinsurers and service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, assessment, investigation and management, including independent medical assessments, and to hold discussions with each other about my claims for such purposes. For clarity, I authorize Oncidium (and as applicable Manulife) to release to various independent medical providers and their assessment teams, all relevant information including medical documentation relating to my medical condition and treatment plan and to forward a copy of my independent medical report(s) to my physician.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) to release information to my Employer or a third party advisor of my Employer for plan administration and analysis purposes only and I acknowledge that my medical information will not be provided to my Employer unless my consent is explicitly obtained.
- Oncidium (and as applicable Manulife), should a return to work be possible, to share with my employer a functional case summary which includes information such as restrictions, limitations and modifications necessary for return to work.
- The Pension Office Corporation (and as applicable Manulife) to use my SIN for the purposes of tax reporting and my member certificate number will be used as an identifier for all other purposes.
- The transfer of my claim file to Manulife in the event that my disability continues beyond a period of 22 months.

I acknowledge that:

- Oncidium reserves the right to undertake an independent medical examination and/or medical assessment/functional evaluation with respect to my disabling condition during the first 22 months of disability and that nothing in this clause affects Manulife's contractual rights regarding assessments.
- Disability benefits from either the Canada Pension Plan or the Quebec Pension Plan are direct offsets from my LTD benefits and that I will ensure that these amounts will be reimbursed when received. I further acknowledge that benefits paid by Worker's compensation (WCB/WSIB/CNESST) as a result of a work-related incident are also direct offsets from my LTD benefit and that I will ensure that these amounts will be reimbursed when received. In the event that an overpayment of benefits exists from the LTD Plan of The Anglican Church of Canada, I agree to repay the full amount owed in a lump sum or from my LTD benefits payable from The Pension Office Corporation or Manulife, whichever is applicable, until the overpayment is recovered in full.
- Any personal information provided to or collected by The Pension Office Corporation and Oncidium (and as applicable Manulife) in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of my personal information will be limited to employees, representatives, reinsurers, and service providers of The Pension Office Corporation and Oncidium (and as applicable Manulife) in the performance of their jobs, as well as persons to whom I have granted access or authorized disclosure and persons authorized by law.
- I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending written instructions to The Pension Office Corporation, Oncidium or Manulife, each as applicable.

Plan member's signature

Date signed (dd/mmm/yyyy)



Group Benefits Plan Member Statement Long Term Disability Claim

Executive Director
Pension Office Corporation
175 Bloor St East,
South Tower Unit 1201
Toronto ON M4W 3R8

1 Employer	Plan contract number 5640	Plan sponsor's name The Anglican Church of Canada		
	Name of employer/diocese			
	Address		Province	Postal code
	Contact	Title	Phone number	Fax number
	Plan sponsor contribution to premiums LTD _____ %			

2 Plan member identification	Name (last, first, initial)			
	Plan member certificate number	Class	Division number	Date of birth (dd/mmm/yyyy)

3 Coverage information	a) What were the plan member's work hours?		
	<input type="radio"/> Full-time HRS/WK _____	<input type="radio"/> Part-time HRS/WK _____	<input type="radio"/> Other HRS/WK _____
b) What was the employment status prior to the disability date?	<input type="radio"/> Actively employed	OR	<input type="radio"/> Leave of absence <input type="radio"/> On layoff <input type="radio"/> Terminated
		<input type="radio"/> Disability leave <input type="radio"/> Pensioned	Please provide effective date (dd/mmm/yyyy)

4 Work schedule information	a) What was the date last worked and the next scheduled work date?	
	Date last worked (dd/mmm/yyyy)	Next scheduled work date (dd/mmm/yyyy)
	b) List any dates plan member worked during the 119 day Qualifying Period.	
c) What is the return to work date?	Return to work date (dd/mmm/yyyy)	<input type="radio"/> Actual <input type="radio"/> Expected <input type="radio"/> Unknown

5 Plan member's earnings and benefit information	a) What was the salary (for pension purposes) when the plan member was last at work?														
	Salary (for pension purposes) \$	Please provide the following information, OR a copy of the current payslip.													
	Other income \$	(Overtime, bonus, shift differential as per policy provisions)	<table border="0"> <tr> <td rowspan="4" style="writing-mode: vertical-rl; transform: rotate(180deg);">PAYMENT SCHEDULE</td> <td><input type="radio"/> Hourly</td> <td><input type="radio"/> Weekly</td> <td><input type="radio"/> Bi-weekly</td> </tr> <tr> <td><input type="radio"/> Semi-monthly</td> <td><input type="radio"/> Monthly</td> <td><input type="radio"/> Annual</td> </tr> <tr> <td><input type="radio"/> Hourly</td> <td><input type="radio"/> Weekly</td> <td><input type="radio"/> Bi-weekly</td> </tr> <tr> <td><input type="radio"/> Semi-monthly</td> <td><input type="radio"/> Monthly</td> <td><input type="radio"/> Annual</td> </tr> </table>	PAYMENT SCHEDULE	<input type="radio"/> Hourly	<input type="radio"/> Weekly	<input type="radio"/> Bi-weekly	<input type="radio"/> Semi-monthly	<input type="radio"/> Monthly	<input type="radio"/> Annual	<input type="radio"/> Hourly	<input type="radio"/> Weekly	<input type="radio"/> Bi-weekly	<input type="radio"/> Semi-monthly	<input type="radio"/> Monthly
PAYMENT SCHEDULE	<input type="radio"/> Hourly	<input type="radio"/> Weekly	<input type="radio"/> Bi-weekly												
	<input type="radio"/> Semi-monthly	<input type="radio"/> Monthly	<input type="radio"/> Annual												
	<input type="radio"/> Hourly	<input type="radio"/> Weekly	<input type="radio"/> Bi-weekly												
	<input type="radio"/> Semi-monthly	<input type="radio"/> Monthly	<input type="radio"/> Annual												

5 Plan member's earnings and benefit information (continued)

c) What is the date of the last salary increase?

Date of last salary increase (dd/mmm/yyyy)

d) Personal income tax exemptions

Federal income tax \$

Provincial income tax \$

e) Does employee reside in a rectory?

Yes No

6 Additional earnings

a) Please indicate if any of the following have been paid (or are payable) since date plan member last worked.

	PAID/PAYABLE	AMOUNT	PERIOD	
Salary continuance	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Sick leave	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Vacation pay	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Short Term disability	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Severance	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Other	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From

7 Workers' compensation information

a) Is the current disability due to a work related accident or illness?

Yes No

If yes, has a claim been filed with the appropriate board?

Yes No

b) Please provide a copy of the Accident/Illness report and:

Workers' compensation board contact name

Phone number

Fax number

Claim number

Date benefit commenced (dd/mmm/yyyy)

Date benefit ceased (dd/mmm/yyyy)

c) What is/was the benefit amount?

Benefit amount \$

Weekly

Bi-weekly

Monthly

d) Is the plan member receiving any other type of workers' compensation income?

Yes No

Permanent award

\$

Effective date (dd/mmm/yyyy)

Workers' compensation board supplements

\$

Effective date (dd/mmm/yyyy)

Lump sum settlement

\$

Payment period

e) If WCB benefits were denied or terminated has plan member appealed this decision?

Yes No

If yes, date of appeal

(dd/mmm/yyyy)

8 Return to work contact

What is the name, job title and phone number of the person in your organization we should contact to facilitate a return to work once this plan member's abilities and limitations are known?

Name	Job title	Phone number
------	-----------	--------------

9 Modified/Alternate work

a) If the plan member could return to work, would modified duties or alternate work be available?

Yes No

If yes, please provide details

b) Has this been discussed with the plan member?

Yes No

10 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

Please attach any medical or other information provided to or obtained by you, relative to the plan member's absence.

11 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Employer's signature	Title
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Employer's phone number	Date (dd/mmm/yyyy)
-------------------------	--------------------

The information in this statement will be kept in a disability benefits file with The Pension Office, Oncidium (and as applicable Manulife) and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any contained herein.

Note: Please see next page and ensure the remainder of this form is completed.

**Please ensure that the remainder
of this form is completed by the
plan member's supervisor.**

**Sections 12 - 16 may be separated
from the rest of the form,
if necessary.**

**13 Work information
(continued)**

f) Please list any office machines, tools or other equipment that the plan member uses in this job.

TYPE OF EQUIPMENT	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14 Job requirements

a) In this section we are gathering information about the plan member's specific physical or psychological job tasks. If you have a physical or psychological demands analysis, please provide it, **OR** complete the following section as applicable.

Activity	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	
		(< 1 hr.)	(1 - 2 hrs.)	(2 - 4 hrs.)	(4 - 6 hrs.)	(> 6 hrs.)	
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Climbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Kneeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bending/Squatting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crouching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crawling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pushing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pulling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fine manipulation; fingers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Simple grasping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fine manipulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fine manipulation; hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Repetitive body motions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reaching - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reaching - at shoulder level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reaching - below shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reaching - side to side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reaching - up and down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lifting/Carrying	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY	
Lifting - floor to waist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent <input type="radio"/> Frequent <input type="radio"/> Constant	
Lifting - waist to shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent <input type="radio"/> Frequent <input type="radio"/> Constant	
Lifting - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent <input type="radio"/> Frequent <input type="radio"/> Constant	
Carrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent <input type="radio"/> Frequent <input type="radio"/> Constant	
Are assistive devices <input type="radio"/> utilized <input type="radio"/> available <input type="radio"/> N/A							
Is your plan member required to work in any of the following conditions?						Yes	No
Exposure to marked changes in temperatures and humidity						<input type="radio"/>	<input type="radio"/>
Being around moving machinery						<input type="radio"/>	<input type="radio"/>
Unprotected heights						<input type="radio"/>	<input type="radio"/>
Exposure to dust, fumes and gases						<input type="radio"/>	<input type="radio"/>
Driving automobile equipment						<input type="radio"/>	<input type="radio"/>
Is the plan member able to change position as comfort requires?						<input type="radio"/>	<input type="radio"/>

PHYSICAL DEMANDS OF JOB

**14 Job requirements
(continued)**

Which of the following categories best describes the psychological demands of your plan member's job?

PSYCHOLOGICAL DEMANDS OF JOB	A. Understanding and memory					
	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	
	Remember locations and routine procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	B. Sustained concentration and persistence					
	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	
	Carry out short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Carry out detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Maintain attention and concentration for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Perform activities within a schedule	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sustain an ordinary routine without supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Make simple decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Solve simple straightforward problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Solve complex problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
C. Social interaction						
SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT		
Interact with the general public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Ask questions or request assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Accept instructions and feedback	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Get along well with others without distracting them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Get along well with others without being distracted by them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
D. Adaptation						
SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT		
Respond to frequent changes in the environment or tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Aware of normal hazards and take appropriate precautions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Travel in unfamiliar places or use public transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Set realistic goals or make plans independently of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Juggle tasks and prioritize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
E. Responsibility and accountability				Yes	No	
Is work pace without the pressure of deadlines?				<input type="radio"/>	<input type="radio"/>	
Does the work involve occasional pressure to meet deadlines?				<input type="radio"/>	<input type="radio"/>	
Does the work involve periodic pressure to meet deadlines?				<input type="radio"/>	<input type="radio"/>	
Does the work involve significant pressures?				<input type="radio"/>	<input type="radio"/>	

14 Job requirements (continued)

b) Before the plan member stopped working, did the illness or injury cause him/her to change:

		Date (dd/mmm/yyyy)	Explanation
Job duties	<input type="radio"/> Yes <input type="radio"/> No		
Job performance	<input type="radio"/> Yes <input type="radio"/> No		
Equipment	<input type="radio"/> Yes <input type="radio"/> No		
Environment	<input type="radio"/> Yes <input type="radio"/> No		
Hours of work	<input type="radio"/> Yes <input type="radio"/> No		
Attendance	<input type="radio"/> Yes <input type="radio"/> No		

15 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

16 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature

Title

Telephone

Date (dd/mmm/yyyy)

The information in this statement will be kept in a disability benefits file with The Pension Office, Oncidium (and as applicable Manulife) and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any contained herein.



**Group Benefits
Initial Attending Physician's Statement
Long Term Disability Claim**

Executive Director
Pension Office Corporation
175 Bloor St East,
South Tower Unit 1201
Toronto ON M4W 3R8

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Plan contract number 5640	Plan member certificate number
<p>"I hereby authorize the release to The Pension Office, Oncidium (and as applicable Manulife) of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. I understand that I am responsible for any fees related to the completion of this form."</p>		
Patient's signature	Date (dd/mmm/yyyy)	

2 Attending physician's statement

Diagnosis

- a) Primary diagnosis:
- b) Additional diagnoses or complications:
- c) **If** psychiatric disorder, provide current GAF score.
- d) **If** cardiac disorder, provide American Heart Association functional classification.

GAF score	
<input type="radio"/> Class I (No limitation) <input type="radio"/> Class III (Marked limitation)	<input type="radio"/> Class II (Slight limitation) <input type="radio"/> Class IV (Complete limitation)

3 Clinical information

Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results (excluding genetic tests) in support of your patient's diagnosis and functional abilities.

- a) What date did symptoms first appear/accident happen?
- b) When did your patient's condition begin?
- c) Is this condition due to:
- d) What is the date of the first visit, the latest visit and the frequency of visits?

(dd/mmm/yyyy)	(dd/mmm/yyyy)
<input type="radio"/> Injury <input type="radio"/> Work-related <input type="radio"/> Motor vehicle accident <input type="radio"/> Other (specify) <input type="radio"/> Illness	
Date of first visit (dd/mmm/yyyy)	Date of latest visit (dd/mmm/yyyy)
Frequency of visits <input type="radio"/> Weekly <input type="radio"/> Bi-weekly <input type="radio"/> Monthly <input type="radio"/> Other (specify)	

**3 Clinical information
(continued)**

e) What are the patient's subjective **symptoms**?

f) How have **symptoms** evolved to date? (Please indicate frequency and severity)

g) What were your initial **clinical findings**?

h) What are your most recent **clinical findings**?

i) Restrictions and limitations

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

- Ambulatory Bed confined Hospital confined
 Ambulatory with assistive devices Home confined

3 Clinical information (continued)

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand <input type="radio"/> Left <input type="radio"/> Right
----------------	----------------	---

l) **If** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)

m) **If** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD OS	Without corrective lenses OD OS	Date of last exam (dd/mmm/yyyy)
---------------------------------	------------------------------------	---------------------------------

n) **If** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

4 Treatment (continued)

e) Treatment response:

- Recovered
- Improved
- No change
- Retrogressed

Comments

f) Is your patient following the recommended treatment program?

- Yes No

If no, please elaborate:

g) Details of any **proposed** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

- Yes No

If no, from what date?

Date (dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

- Yes No

- Restricted Suspended Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.

Name of attending physician (please print)		
Specialty	Telephone (include area code)	Fax (include area code)
Address (number, street and apartment)		
City	Province	Postal code
Signature	Date signed (dd/mmm/yyyy)	

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