ECHELON GENERAL INSURANCE COMPANY

Attending Physician Statement (APS)
Long Term Disability Application

Claimant Information and Authorization to Release Information - Claimant to complete

Last Name:____________________ First Name: ____________________

Employer Name: ______________________________________

Employee #: ____________________ Date of Birth: ____________________

I hereby authorize the release, to Unistar Special Risks Inc of any medical information requested in this form, including copies of hospital records and consultation reports, with respect to this claim.

Signature of Claimant: ____________________ Date Signed: ____________________

Physician Questionnaire - Attending Physician to complete

It is the claimant's responsibility to provide medical information to support the application and to pay any costs incurred in obtaining this information. *This is not* a *request for examination, but for information taken from your chart. This claimant* is *applying for Long Term Disability benefits. For additional information, please contact Unistar SRI toll-free at 877.900.0250 (Confidential fax number is:* ***800.364.0754****).*

Thank you.

Diagnosis

Primary diagnosis: ______________________________________

Severity: ☐ mild ☐ moderate ☐ severe

Additional diagnoses or complications:

If psychiatric disorder, complete the current axial diagnosis and the functional "GAF score".

AXIS I: ____________________
AXIS II: ____________________
AXIS III: ____________________
AXIS IV: ____________________

AXIS V (GAF SCORE)
Current GAF Score: ____________________
Highest GAF Score in the past Year: ____________________
Lowest GAF Score in the past Year: ____________________

If cardiac condition, please specify the functional class.

A. Functional Capacity ☐ Class 1 (No limitation) ☐ Class 3 (Marked limitation) ☐ Class 2 (Slight limitation) ☐ Class 4 (Complete limitation)

B. Therapeutic Class (Activity) ☐ No restriction ☐ Slight restriction ☐ Moderate restriction ☐ Marked restriction ☐ Complete restriction

C. Blood Pressure - Last visit ____________________

*Claimant's Name:*________________________________ *Claimant's Date of Birth (m/d/y):*_________________________

History and Clinical Information

Date symptoms first appeared or accident occurred (m/d/y): ______________________________________

Date patient ceased to work because of the incapacity (m/d/y): ____________________________________

Date of patient's first visit (m/d/y):_____________________ Date of patient's last visit (m/d/y): ________________

Date of patient's next visit (m/d/y): ____________________

Frequency of visits:
☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (specify) __

Is the patient's condition pregnancy-related? ☐ Yes ☐ No If "Yes", EDD ______

Is the patient's condition due to injury or illness related to his/her job or to a motor vehicle accident? ☐ Yes ☐ No
If "Yes", please specify and explain. (☐ Work Related ☐ Motor Vehicle Accident)

Has the patient ever had the same or a similar condition? ☐ Yes ☐ No If "Yes", please specify diagnosis and dates of treatment.

Current height: ______________________________ Current weight: ____________________________________

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings) and medical history relevant to current medical condition causing absence from work. Please include a copy of your clinical notes, tests & any specialist reports.

What are the patient's subjective symptoms? How have symptoms evolved to date?

What were your initial clinical findings?

*Claimant's Name:*________________________________ *Claimant's Date of Birth (m/d/y):*________________________

What were your most recent clinical findings?

In your opinion, when did the patient's condition first prevent him/her from working? *(m/d/y):* ________________

Treatment

Please list other Physicians who have been/will be involved in assessing the medical conditions.

Name	Specialty	Date seen or to be seen	Telephone

Was hospitalization and/or surgery required? ☐ No ☐ Yes If "Yes", state when and describe the procedure.

Please specify if the patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Recommended or prescribed treatments (indicate medications on the next section):

*Claimant's Name:*________________________________ *Claimant's Date* of *Birth (m/d/y):*________________________

Medication(s):

Medication	Dosage/frequency	Duration	Start Date (d/m/y)	Response (good, moderate, poor)

Is the patient following the recommended treatment program? ☐ Yes ☐ No If "No", please explain.

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Treatment response:

☐ Worsened ☐ No change ☐ Improved ☐ Recovered

Restrictions and Limitations

Please indicate your patient's current physical abilities:

☐ Sedentary Duties:	requires mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.
☐ Light Duties:	requires frequent handling of loads of up to 5kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg control.
☐ Medium Duties:	requires frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.
☐ Heavy Duties:	require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

Please comment further on any physical limitations arising from this condition, if any.

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Please comment on any psychological /psychiatric limitations arising from this condition, if any.

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*Claimant's Name:*_______________________________ *Claimant's Date* of *Birth (m/d/y):*________________________

Prognosis

Please indicate prognosis: ____

In your opinion, what is the earliest date your patient will be able to return to work or normal activities of daily living? *(d/m/y):* ___________________

If the patient's previous job could be modified, when can a modified return to work program commence? *(d/m/y):* _________________________

Additional Remarks

Please include any further comments that you feel may assist us in understanding your patient's condition, restrictions, expected duration of the disability, etc.

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Information about the Attending Physician

Physician's Name ***(Please Print)****:* ____

Address: ___________________________________ Postal Code: ____________________________________

Phone Number: ______________________________ Fax Number: _____________________________________

Specialty: _________________________________ License Number: __________________________________

Signature: _________________________________ Date: ____

Mailing Address:

Suite 850 -10655 Southport Rd. SW, Calgary, AB T2W 4Y1