COUGHLIN & ASSOCIATES LTD.

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# SHORT TERM DISABILITY CLAIM FORM - INITIAL ASSESSMENT

## Part 1 - CLAIMANT'S STATEMENT

Ask your doctor to complete the Attending Physician's Statement on the reverse side. When both sides of the form are completed and **signed,** send the completed form to the Plan Administrator's Office at the address listed above for processing.

### SECTION A: GENERAL INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ Male ☐ Female Date of Birth _____ (Day Month Year)

Surname _____ Given Name _____ Social Insurance Number ☐☐☐ ☐☐☐ ☐☐☐

Street Address _____ City _____ Province _____ Postal Code _____ Telephone Number _____

Group Plan Name _____ Occupation _____ Name of Employer _____ Employer's Phone Number _____

### SECTION B: CLAIM INFORMATION

Was the reason you stopped working due to:
☐ Illness
☐ Motor Vehicle Accident (not while working)
☐ Injury away from work
☐ Occupational Illness or Work Accident

If you have suffered an injury, please describe how, when, and where the injury occurred. _____

What was the last day you worked? _____ (Day Month Year) Were you performing: ☐ Regular Duties ☐ Modified Duties

What was the date you were first unable to work? _____ (Day Month Year)

Please describe all your symptoms, including frequency and severity. _____

When did you first notice these symptoms? _____ (Day Month Year)

When were you first treated by a physician? _____ (Day Month Year)

Have you ever had the same or similar illness or injury? ☐ Yes ☐ No

If yes, please provide dates and name(s) of Physicians who treated you at that time. _____

Please describe the major duties of your occupation. _____

Please describe why you are unable to perform the duties of your occupation. _____

Do you have an expected date of return to work? ☐ Yes ☐ No If yes, please provide date: _____ (Day Month Year)

### SECTION C: OTHER INCOME INFORMATION

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit proof of payments, if applicable.

| Source | Claim #, Contact Name, & Telephone No. | Have you applied? Yes | Have you applied? No | Are you receiving payment? Yes | Are you receiving payment? No | Are you receiving payment? Pending | Monthly Amount |
|---|---|---|---|---|---|---|---|
| Worker's Compensation | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Employment Insurance | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Auto Insurance | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Other Insurer | | ☐ | ☐ | ☐ | ☐ | ☐ | |

### SECTION D: EMPLOYEE AUTHORIZATION AND DECLARTION

**I permit** any physician, dentist or other authorized person or organization in possession of my personal records to provide Coughlin & Associates Ltd. with any information necessary, including hospital records and clinical notes, to administer my claim. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following person, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. **I agree** that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

**I understand** that the information contained in this form, once completed and submitted to Coughlin & Associates Ltd., will be used in the administration of my claim as well as for statistical analysis.

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

Date _____ Signature _____

**Protecting your personal information:** The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of any organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access; and to persons authorized by law.

## Part 2 - ATTENDING PHYSICIAN'S STATEMENT - INITIAL ASSESSMENT

### Authorization/Consent

I authorize any licensed physician, medical practitioner or health care professional who has observed me for diagnosis or treatment, any hospital, clinic, or other medical or medically related facility where I have been a patient, any public body, private health or social establishment, personal information agency, market intermediary, insurance company, institution, current or former employer, or person, to release to Coughlin & Associates Ltd. or its agents the documentation they require to administer this claim. I authorize Coughlin & Associates Ltd. to release such documentation to independent medical examiners, to my Plan Sponsor/Employer and to any other insurance company, organization, establishment or body when Coughlin & Associates Ltd. deems it necessary for the purpose of administering this claim. A photostat of this authorization is as valid as the original.

Patient Name _____ Patient Signature _____ _____
Day Month Year

**Note: The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.**

### SECTION A: DIAGNOSIS

What is the primary diagnosis? _____

When did symptoms first appear or date accident occurred? _____
Day Month Year

What was the date of the patient's first visit for his/her condition? _____
Day Month Year

Please indicate all dates of visits for the current condition:

| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Planned frequency of visits: ☐ Weekly ☐ Monthly ☐ Other, specify: _____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, please elaborate: _____

_____

Is the patient's condition due to injury or sickness arising out of his/her employment? ☐ Yes ☐ No

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? ☐ Yes ☐ No

If yes, please elaborate: _____

Please list the patient's symptoms (Including severity and frequency) identifying which of the symptoms listed you have objectively observed:

_____

_____

What are the patient's current limitations? Please be specific. _____

_____

What are the patient's current restrictions? Please be specific. _____

_____

Please indicate the date the patient stopped working based on your recommendation. _____
Day Month Year

To the best of my knowledge, the patient has been totally disabled,

**From** _____ **To** _____
Day Month Year Day Month Year

Please provide date when patient should be able to return to work. _____
Day Month Year

### SECTION B: TREATMENT

Has the patient been hospitalized? ☐ Yes ☐ No

If yes, please provide the name of the hospital and the date(s) of confinement. _____

If surgery was performed, please provide a description and date(s). _____

Please detail the patient's past and present treatment as well as response to treatment. _____

_____

Please list all medications that the patient is currently taking, including dosage and date prescribed.

| Medication | Dosage | Date Prescribed (D/M/Y) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If you have referred the patient to a specialist, please provide the name of the specialist(s) and area of speciality. _____

_____

_____ _____ _____
Name (please print) Address Telephone No.

_____ _____ _____
Date Signature Speciality