

*Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.  
 It is the responsibility of the plan member to submit the Employee Statement and Attending Physician Statement.  
 The plan member is responsible for submitting this completed form and accepting any charges for its completion.*

**1. This section to be completed by employee (plan member)**

Last name		First name		Middle initial	Birth date (YYYY-MM-DD)		Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Mailing address			City/town			Province	Postal code		
Home telephone	Cell phone		Email address			Dominant hand <input type="checkbox"/> Left <input type="checkbox"/> Right		Height	Weight
Employer's name		Group/policy number	Section	ID number	Date last worked (YYYY-MM-DD)	Date returned to work/expected return date (YYYY-MM-DD)			

Please list your present medications

Name of medication	Dosage (mg)	How often?
1.		
2.		
3.		
4.		
5.		

I hereby authorize the release of health information in my file by the health care provider listed on this form to Alberta Blue Cross, Blue Cross Life Insurance Company of Canada\* and/or its authorized agents for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claims management. This health information includes, but is not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results.

I understand that I can revoke this consent at any time in writing; however, if consent is withheld or revoked coverage may be denied or rescinded.

I understand why I have been asked to disclose this information, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

I agree that this consent shall be effective on the date noted below and shall be valid for the duration of the time my benefit coverage is in force.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to [ab.bluecross.ca](http://ab.bluecross.ca) or email our privacy compliance officer at [privacy@ab.bluecross.ca](mailto:privacy@ab.bluecross.ca).

Signature of employee (plan member)	Date of consent (YYYY-MM-DD)
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**2. Attending physician statement TO BE COMPLETED BY THE DOCTOR**

I am the  Attending physician  Consulting specialist  Other (please specify) \_\_\_\_\_

**PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE**

**1. Diagnosis**

<b>1.</b>	Primary diagnosis
	Secondary and/or complications

If childbirth—expected or actual delivery date (YYYY-MM-DD) <input type="checkbox"/> vaginal <input type="checkbox"/> c-Section		Occupational illness/injury <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of the event (YYYY-MM-DD)	Auto accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of the event (YYYY-MM-DD)
Have you completed any other disability claim forms recently for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate requestor (other insurance company, CPP, QPP, Workers Compensation Board, etc.)	
Date of first visit to you pertaining to this condition (YYYY-MM-DD)		First date of work absence due to condition (YYYY-MM-DD)	

**2. Treatment** For example, special programs, therapies, medications (if not noted by patient in **Section 1**)

Frequency of visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (describe) _____			Date of last visit (YYYY-MM-DD)
Has the patient been treated for this same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date (YYYY-MM-DD)	Treatment provider	
Is the patient following the recommended treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No Please elaborate			


**3. Response to treatment**

Please describe the response to treatment to date <input type="checkbox"/> Complete <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> Too soon to tell	
Are there any plans to change or augment the current treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No Please elaborate	

**4. Hospitalization**

Is/was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is future hospitalization planned? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of admittance (YYYY-MM-DD)	Date of discharge (YYYY-MM-DD)	Institution name	
1.			
2.			
3.			
If surgery was/will be performed, please provide date(s) and description of surgery(s)			
Date (YYYY-MM-DD)	Description		
1.			
2.			

**5. Investigation**

 <b>Please attach copies of all relevant:</b> <ul style="list-style-type: none"> <li>• test results and investigations (if test results are not attached, we will interpret this as tests were not performed)</li> <li>• consultation reports</li> </ul> <b>Do not provide genetic test results.</b>			
Are tests/investigations pending? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date (YYYY-MM-DD)	Description		
1.			
2.			
If consultation report is not attached, will the patient be seen by specialists for this condition in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of specialist	Specialty		Date (YYYY-MM-DD)
1.			
2.			

6. Clinical findings and observations	
Please describe the patient's symptoms including history, severity and frequency	
How have the patient's symptoms evolved to date? <input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Retrogressed	
7. Restrictions and limitations	
Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations	
Has any license held by the patient been restricted or revoked as a result of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, as of when? (YYYY-MM-DD) Type of license
Do you have concerns about the patient's ability to manage his or her own affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please elaborate	
8. Prognosis	
Please provide the patient's prognosis for improvement and recovery	
9. Return-to-work	
What return-to-work goals have been discussed with the patient? Please elaborate	

### 3. Notice to physician

**The information in this statement will be kept in a life, health or disability benefits file with the insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.**

Name of attending physician	Physician's specialty		Physician's stamp
Mailing address	Province	Postal code	
Phone number	Fax number		
Signature	Date signed (YYYY-MM-DD)		

\*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.

\*\* The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. \* † Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association.  
ABC 55085/31043 Physician's Statement General Long Term Disability 2017/12

