CHUBB

ATTENDING PHYSICIAN'S
INITIAL STATEMENT OF DISABILITY
WEEKLY ACCIDENT
INDEMNITY BENEFITS

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PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Patient's Name:	**Age:**

The patient is responsible for the securing of this form and any charge, which may be made for completion.

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

TO PHYSICIANS - PLEASE NOTE As you can appreciate, the information provided by you is the most important in our assessment of impairment. We are asking for your cooperation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

HISTORY

a) Is this condition due to ☐ sickness or ☐ accident?			
If due to an accident, please provide complete details of accident.			
b) When did symptoms first appear or accident happen?	**Month:**	**Day:**	**Year:**
c) Date total disability commenced?	**Month:**	**Day:**	**Year:**
d) Has patient ever have same or similar condition? ☐ Yes ☐ No ☐ Unknown			
If "Yes," state when and describe:			

DIAGNOSIS

a) Diagnosis (including any complications)
Secondary (if applicable):
b) Objective findings (including results of current x-rays, E.C.G.'s or any other special tests)

TREATMENT

a) Date of first visit	**Month:**	**Day:**	**Year:**
b) Date of last visit	**Month:**	**Day:**	**Year:**
c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify):			
d) Has there been a treatment program set up? ☐ Yes ☐ No If "Yes", please provide full details.			
e) Has the patient had surgery in relation to this condition? ☐ Yes ☐ No If "Yes", please provide full details.			
Name of Procedure(s)			
Date (s) performed	**Month:**	**Day:**	**Year:**
f) Name of hospital and date of hospitalization:			

PHYSICAL IMPAIRMENT

Is patient ☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined
If ambulatory and/or house confined, please complete the section below.
☐ No limitation of functional capacity; capable of strenuous activity
☐ Medium limitation of functional capacity; capable of light activity
☐ Minimal limitation of functional capacity; capable of moderate activity
☐ Severe limitation of functional capacity; Incapable of minimal activity
Remarks:
What are the patient's physical impairments?

PROGNOSIS

a) Does condition prevent patient from performing?	**Regular Occupation ☐ Yes ☐ No**	**Any Other Occupation ☐ Yes ☐ No**
b) If "Yes", please indicate when you expect patient will recover sufficiently to perform duties of		
Regular Occupation	**☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:**	
Any Other Occupation	**☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:**	
c) If "No", please indicate date patient was able to perform duties of		
Regular Occupation	**☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:**	
Any Other Occupation	**☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:**	

REHABILITATION

a) Is patient a suitable candidate for trial employment?	**Regular Occupation ☐ Yes ☐ No**	**Any Other Occupation ☐ Yes ☐ No**
b) If "Yes", when could trail employment commence?		
☐ Full Time Month: Day: Year:	**☐ Part Time Month: Day: Year:**	
If "No", please explain.		

REMARKS

PLEASE PROVIDE COPIES OF ALL DIAGNOSTIC TEST RESULTS AND CONSULTATION REPORTS PERTINENT TOTHE ABOVE NOTED CONDITION.

Physician's Name:		
Degree:	**Phone: ( )**	**Fax: ( )**
Address:		
City:	**Province:**	**Postal Code:**

Signature _____ Date _____