OTIP RAEO®

OTIP
Group Life and Disability Claims
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Attending Physician's Statement of Disability

This form should be completed in full based on the provider's direct examination and supported by clinical evidence. No section of the form (except for authorization and member information section) should be completed by the member. The information provided will assist in better understanding your patient's condition, treatment, prognosis and potential for recovery. **Print neatly and retain a copy of this form for your records.**

Attach copies of all unredacted medical documents from the date last worked to present:
- **Test results/investigations**
- **Consultation reports/Specialist assesments/Referrals**
- **Clinic notes**

Note: if the above has not been included, this will delay the processing of your patient's claim, and we may make a decision without it. The patient is responsible for all expenses related to the completion of this form including the cost for copies of clinical records/test results, etc.

MEMBER INFORMATION AND AUTHORIZATION (To be completed by the patient)

Name (Last, First and Middle Initial)			Preferred Pronoun
Address (Number, Street and Apt.)			
City		Province	Postal Code
Telephone Number		Alternate Telephone Number	Date of Birth *(mm/dd/yyyy)*
Employer/School Board			
Height ft/cm	Weight lbs/kg	Last Date Worked *(mm/dd/yyyy)*	Date expected to return to work/ returned to work date *(mm/dd/yyyy)*

AGREEMENT, ACKNOWLEDGMENT AND AUTHORIZATION OF PATIENT

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 facility where I have been a patient to release to the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") any personal health information, including but not limited to, copies of consultation reports, clinical notes, test results, my medical history, treatment, independent medical assessments and hospital records, for the purposes of benefits plan administration, audit, and the assessment, investigation and management of my claim.

I authorize OTIP to collect, use and disclose information needed for the adjudication of my claim with any person or organization noted above who has relevant information pertaining to my claim. I agree that this authorization is valid for the duration of my claim. I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

I understand that I am responsible for any fees related to the completion of this form.

Signature (Patient): _____ Date: *(mm/dd/yyyy)* _____

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Current Diagnosis

This form should be completed based on the provider's direct examination and supported by clinical evidence. (To be completed by the Physician)

Primary: _____

_____

_____

Secondary: _____

_____

_____

If childbirth — Expected or Actual delivery date: *(mm/dd/yyyy)* _____

Is this condition related to: ☐ Occupational illness/injury ☐ Auto accident

If so, date of event: *(mm/dd/yyyy)* _____

Details: _____

_____

_____

Date of first visit to you pertaining to this condition: *(mm/dd/yyyy)* _____

First date of work absence due to this condition: *(mm/dd/yyyy)* _____

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: *(mm/dd/yyyy)* _____ By whom: _____

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workplace Safety & Insurance Board, etc.)

_____

Current Description of Symptoms

Symptoms	Frequency	Severity

Are the Symptoms: ☐ Self-reported or ☐ Observed and reported by the Physician

How have your patient's symptoms evolved to date: ☐ Improved or ☐ No Change

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Complicating Factors (Check all that apply)

Please indicate all factors that may have contributed to the clinical picture and may complicate the patient's recovery period:

☐ Alcohol/Drug ☐ Medication side effects ☐ Physical condition

☐ Coping Skills ☐ Pain perception ☐ Social/Family

☐ Financial/Legal ☐ Personality/Motivation ☐ Workplace ☐ Other

Please Describe: _____

_____

_____

_____

_____

If the workplace is a factor, indicate if patient can return to work in another environment or begin a gradual return to work:

☐ Yes ☐ No

If yes, provide further details _____

_____

_____

_____

_____

Investigations

Attach copies of all unredacted medical documents from the date last worked to present:

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Are tests/investigations/consultations pending? ☐ Yes ☐ No Date report expected: *(mm/dd/yyyy)* _____

Does the patient have an appointment booked with any specialist(s) ? ☐ Yes ☐ No

Name of specialist	Specialty	Date of appt: *(mm/dd/yyyy)*
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____

Reason for requesting the consultation: _____

_____

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Medications (Please attach a separate list if insufficient space)

Medication name	Initial dosage and date started *(mm/dd/yyyy)*	Current dosage and date changed if applicable *(mm/dd/yyyy)*	Frequency	Response

Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization anticipated? ☐ Yes ☐ No

Date admitted *(mm/dd/yyyy)* Date discharged *(mm/dd/yyyy)* Hospital name

1. _____ 1. _____ 1. _____

2. _____ 2. _____ 2. _____

If surgery was/will be performed, please provide date(s) and description of surgery(ies):

Date *(mm/dd/yyyy)* Description

1. _____ 1. _____

2. _____ 2. _____

Treatment Details (e.g. CBT, drug/alcohol, group therapy, marital therapy, day hospital program, physiotherapy, etc.)

Type of therapy	Name of provider or facility	Date treatment began *(mm/dd/yyyy)*	Frequency of Visits	Date of last visit *(mm/dd/yyyy)*	Progress

Overall Response to Treatment

Please describe the response to treatment to date: ☐ Recovered ☐ Improved ☐ No change

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please explain: _____

_____

_____

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain: _____

_____

_____

Restrictions and Limitations

Attach copies of all unredacted medical documents from the date last worked to present:

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Physical Impairment (Check If Applicable)

☐	No Limitation of functional capacity (0-15%)
☐	Slight limitation of functional capacity (16-30%)
☐	Moderate limitation of functional capacity (31-55%)
☐	Marked limitation of functional capacity (56-70%)
☐	Severe limitation of functional capacity (71-100%)

Is the Patient (Check If Applicable)

☐	Ambulatory	☐	Using crutches/cane	☐	In Wheelchair
☐	House-confined	☐	Bed-confined	☐	Hospital-confined

Cognitive/Psychological Impairment (Check If Applicable)

☐	Able to function under stress and engage in interpersonal relationships (no limitation)
☐	Able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐	Able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐	Unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐	Has suffered loss of psychological, physiological, personal and social adjustment (severe limitations)

If the patient has a cognitive/psychological condition, has there been a specialist (psychologist/psychiatrist) referral? ☐ Yes ☐ No

If yes, to whom (attach report): _____

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Are you aware of the patient's job functional requirements, schedule, work environment, etc.?

☐ Yes ☐ No ☐ Somewhat aware

What are the patient's limitations and restrictions related to their specific assignment?

Limitations (What the patient CANNOT do)	Restrictions (What the patient SHOULD NOT do)

What, if any, improvements are required for your patient to be able to consider a return-to-work in modified or full form?

_____

_____

_____

_____

_____

Based on the patient's job duties, what are they still capable of doing? _____

_____

_____

What are the patient's limitations and restrictions related to their Activities of Daily Living?

Limitations (What the patient CANNOT do)	Restrictions (What the patient SHOULD NOT do)

Has any licence held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No

If yes, what kind and as of when? *(mm/dd/yyyy)* _____

Do you have concerns about the patient's ability to manage their own affairs? ☐ Yes ☐ No

Return-to-Work/Prognosis and Recovery

(OTIP encourages rehabilitation assistance, modified work or light duties to return an employee to the workplace as soon as medically possible)

When can the patient initiate a return-to-work — full-time, part-time or modified schedule: *(mm/dd/yyyy)*

_____

What factors present barriers to starting a return-to-work process? _____

_____

ATTENDING PHYSICIAN STATEMENT (CONTINUED)

Is the patient's work absence within a reasonable and expected duration for the diagnosed condition(s)?

If not, please explain. _____

_____

_____

Provide the patient's prognosis for improvement: ☐ Good ☐ Poor ☐ Guarded

Provide any other information that will help us understand the patient's current condition, recovery goals and prognosis: _____

_____

_____

AUTHORIZATION OF ATTENDING PHYSICIAN

I certify that the information in this form, and any further verbal or written statement provided by me in the future concerning this claim, is true and complete to the best of my knowledge. I understand that the information in this form will be kept in a benefits health file relating to this claim and might be accessible by third parties to whom authorized access has been granted. I acknowledge and agree that by signing this document I consent to the unedited disclosure of any information contained herein, to the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP").

Name (Last, First and Middle Initial)	Physician's Stamp	
Address (Number, Street and Apt.)		
City	Province	Postal Code
Telephone Number	Fax Number	Specialty
Signature (Attending Physician)	Date *(mm/dd/yyyy)*	