SUTTON
SPECIAL RISK

Tel: 416.366.2223
Toll Free: 1.800.461.3292
claims@suttonspecialrisk.com

Proof of Total Disability - Physician's Statement

Please complete in block letters and give to the patient. The insured must pay the fees requested to complete this form.

A - STATEMENT

Employee Name	Policy Number
Telephone Number	Date of Birth (YYYY/MM/DD)

Mental Condition
Is the patient competent to endorse cheque and direct the use of the proceeds thereof?

B - DIAGNOSIS

Primary

Secondary

Complications

For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments ☐ consulted another physician ☐ taken drugs ☐ been hospitalized ☐ undergone examinations

Specify the periods: _____

Is the disability related to:

☐ an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident

Date of the event (YYYY/MM/DD) _____

Describe the functional limitations that prevent the patient from carrying out professional duties or usual activities

At the beginning of the disability (YYYY/MM/DD): _____	Currently:

C - TREATMENT

Drugs - name - dosage: _____

Has the patient undergone or will undergo:

a) examinations or tests ☐Yes ☐No Specify: _____

b) surgery ☐Yes ☐No Day Surgery ☐ Type: _____

Surgical procedure: _____ Date (YYYY/MM/DD): _____

c) other treatments ☐Yes ☐No

d) hospitalization: From _____ To _____ Name of hospital: _____

e) a short stay under observation ☐Yes ☐No Number of hours: _____

Return Completed Forms to Sutton Special Risk
33 Yonge St., Suite 400 Box 311
Toronto, ON M5E 1G4

D - FOLLOW-UP AND PROGNOSIS

Date of first consultation for this disability (YYYY/MM/DD): _____ Next consultation: _____

Date of other consultations (YYYY/MM/DD): _____ Follow-up frequency: _____

Referral to another physician: ❒Yes ❒No Name of Physician: _____

Specialty: _____

Approximate duration of disability: No. of days: _____ No. of weeks: _____ Unspecified❒ or date of return to work (YYYY/MM/DD): _____

How long before the patient will be able to return to work: No. of days: _____ No. of weeks: _____

❒Part-time ❒Full-time ❒Gradual return Specify: _____

E - ADDITIONAL INFORMATION

F - IDENTIFICATION OF THE PHYSICIAN

Family name, given name: _____

License number: _____ Telephone: _____ Fax: _____

❒General Practitioner ❒Specialist Specify: _____

Signature Date (YYYY/MM/DD)