SUTTON
SPECIAL RISK

33 Yonge Street, Suite 400
Toronto, Ontario M5E 1G4
Tel: (416) 366-2223
Fax: (416) 366-4608
Toll Free: 800-461-3292

Proof of Permanent Total Disability

Employer's Statement **Please attach: Photocopy of employee enrollment card or proof of enrollment.**

Certificate Holder			
Date Coverage Commenced			
Amount of Insurance $		Amount of Claim $	
Dated at	this	day	20

Signature Official Position Telephone or email contact

Claimant's Statement **Please attach:** Completed Physician's statement

Details of Illness or of Accident (if applicable)

Date and time of Accident Month Day Year ○ AM ○ PM	Did accident occur on or off duty? ○ YES ○ NO
Please explain details of accident or illness fully.	
On what date were you first treated by physician?	Onset of Disability
Have you had the same or similar condition previously?	If yes, please provide dates
Names and address of all attending physicians?	

I hereby certify that the above statements made by me are complete, true and correctly recorded.

Employee Signature Witness Date

Authorization to obtain information

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my eligible children to give Sutton Special Risk, or its legal representative any and all such information pursuant to this claim.

I UNDERSTAND the information obtained by use of this Authorization will be used by Sutton Special Risk, to determine eligibility for coverage or eligibility for benefits under existing coverage. Any information obtained will not be released by Sutton Special Risk, to any person or organization except to the Insurer, or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two years from the date shown below.

Employee Signature Witness Date

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Proof of Permanent Total Disability

Physician's Statement

Employee Name	Telephone no.
Employee Address	

1. Name of Patient

2. Date of Accident or onset of illness:

Date Patient ceased work because of disability:

Is patient: ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

3. Extent of Disability

a) Is patient totally disabled? ☐ For any occupation? ☐ For his/her regular occupation?

b) If no, when was patient able to go to work? _____

c) If yes, when do you think patient will be able to resume any work? Approx. date:_____Indefinite_____Never _____

d) If yes, is patient a suitable candidate for a rehabilitation program?

4. Treatment

a) Date of first visit_____b) Date of Last visit_____c) Frequency of visits _____

5. Progress

☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

6. Your diagnosis and a complete description of injuries sustained:

7. Were the injuries or impairment sustained due solely to the above accident?
If not, please give details of any condition or disease which in your opinion may have served as a contributory cause.

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

M.D.

Signature Date

Address