BRITISH COLUMBIA
BC Public Service
Where ideas work

To the Attending Physician*

Concerning Your Patient's Application for Long Term Disability Benefits Claim

Please note: Employees must submit all portions of their completed LTD Plan application, including the Physician* portion, within four weeks following the end of the STIIP period. If an employee fails to submit their application within that time, they will be presumed to have abandoned their claim. If an employee has not abandoned their claim, they must then demonstrate to the plan administrator that there were reasonable grounds for not having applied during the prescribed period.

The design of our plan and Canada Life Assurance Company's (Canada Life) administration of claims are based on the belief that everyone stands to gain if the employee returns to productive work within medical restrictions in a timely manner.

You play an important role in your patient's Long Term Disability (LTD) benefit claim. Please remember that:

- LTD benefits are provided by your patient's employer, the Province of British Columbia and other covered public sector employers in the Province. The LTD plan is funded by contributions made by the employers. Claims are assessed by Canada Life in Vancouver.
- Please complete the Attending Physician* Initial Statement. This can be accessed electronically (see website noted below to access forms). Attach **all** relevant test results, x-ray reports and/or specialists' reports that support your diagnosis. The complete forms can be emailed, faxed or mailed to the address below.
- The Psychiatric Condition Statement is to be completed only in the event psychiatric illness is present.
- **The patient is responsible for the cost for the completion of these forms and for any charges incurred**.

As you are aware, this is a difficult time for your patient. You can greatly assist in the claims review process by promptly sending in complete medical information, and by supporting your patient in an appropriate rehabilitation plan. Thank you for your cooperation.

Canada Life Assurance Company
Suite 1500 -1055 Dunsmuir Street
Vancouver BC V7X 1K8
Toll Free: 1-888-292-4111
Fax: 1-844-816-1038
Email: Vancouver.DMSO@CanadaLife.com

Forms available at: **www2.gov.bc.ca/myhr** (search for Long Term Disability Application)

*** Effective April 1, 2022, BC General Employees' Union, Professional Employees' Association, and excluded employees may have their LTD application forms completed by an attending Nurse Practitioner. Please refer to your collective agreement or terms and conditions of employment for further information.**

Employee Name	Employee Number

Clear Form

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Attending Physician* Initial Statement
Claim for Long Term Disability Benefit

Freedom of Information and Protection of Privacy Act (FOIPPA) The personal information requested on this form is collected under the authority of FOIPPA s.26(c) and will be used to process your application for Long Term Disability benefits and for return-to-work planning. Questions about the collection or use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request at AskMyHR, phoning 1-877-277-0772, or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard St. Victoria, BC V8W 2H2.

Physician* – Important Notice

The detailed completion of this form is of vital importance to the patient, as this medical evidence is essential to enable the patient's benefits to be processed. Please complete these sections relating to your patient and stroke out non-applicable areas. The back page is available to expand on comments under any of the headings or to add other information relevant to the claim. This form may be emailed, mailed or faxed directly to Canada Life Assurance Company (Canada Life) or given to the patient at the physician's discretion.

Identification

Patient's Name

Date of Birth (yyyy-mm-dd)	Age	Current Height	Current Weight

History

Date symptoms first appeared or accident happened: (yyyy-mm-dd)

Date of first visit by patient for this condition: (yyyy-mm-dd)

Date of latest visit by patient for this condition: (yyyy-mm-dd)

Frequency of visits: ◯ Weekly ◯ Monthly ◯ Other

Is the condition due to injury or sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown

Has patient ever had the same or similar condition? ◯ Yes ◯ No

From what date did your patient's medical condition prevent him/her from working? (yyyy-mm-dd)

Please attach copies of clinical notes from the date of disability. Have these been included? ◯ Yes ◯ No

Other physician(s)* who have been involved in your patient's care:

Note: Please attach consultation reports of these specialists. These are required before an assessment can be completed.

Physician*	Specialty	City	Date of referral (yyyy-mm-dd)

Was your patient hospitalized for this illness or injury? ◯ Yes ◯ No

List any surgical procedures performed:	Date(s): (yyyy-mm-dd)	Name of surgeon(s):

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Attending Physician* Initial Statement
Claim for Long Term Disability Benefit

Diagnosis

Primary:

Secondary:

Please list the most disabling symptoms:

Objective signs (including results of current x-rays, EKG reports, blood pressure, laboratory data and any relevant clinical findings).
Please enclose copies.

Is the patient: ◯ ambulatory ◯ houseconfined ◯ bedconfined ◯ hospital confined?

What recovery and return to work expectations do you have for your patient?

NOTE: If a psychiatric illness is present please complete the Attending Physician* Initial Statement form as well as the psychiatric section in the Psychiatric Condition Statement

Treatment

What is the current treatment regimen? Please include details of drugs and dosage, physiotherapy, other treatments and patient's progress.

Is the patient following recommended treatment plan? ◯ Yes ◯ No

Please outline future treatments and pending investigations if any.
Please include details of any pending surgery and estimated wait for such surgery.

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Return to Work Planning

What is the earliest estimated date on which improvement will allow a return to work?

To their own occupation with or without accommodation?	Part-time (yyyy-mm-dd)	Full-time (yyyy-mm-dd)
To an alternate occupation?	Part-time (yyyy-mm-dd)	Full-time yyyy-mm-dd)

Please list any further treatment or recovery supports that would improve their capacity for work.

Functional Limitations

Functional Scale where:

Mild Impairment is capable of most useful functioning.
Moderate Impairment is capable of some but not all useful functioning.
Marked Impairment is useful functioning significantly impaired.
Extreme Impairment is incapable of useful functioning.

Degree of Limitation

Function	None	Mild	Moderate	Marked	Extreme	Don't know
Cognition	◯	◯	◯	◯	◯	◯
Speaking	◯	◯	◯	◯	◯	◯
Hearing	◯	◯	◯	◯	◯	◯
Sensation	◯	◯	◯	◯	◯	◯
Psychological	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯
Sitting	◯	◯	◯	◯	◯	◯
Bending	◯	◯	◯	◯	◯	◯
Lifting (max. weight kg) _____	◯	◯	◯	◯	◯	◯
Dexterity	◯	◯	◯	◯	◯	◯
Vision	◯	◯	◯	◯	◯	◯

Please add any other functions limited by the condition:

_____	◯	◯	◯	◯	◯	◯
_____	◯	◯	◯	◯	◯	◯

Describe any physical functional limitations that affect your patient's ability to work:

Could the employee's medical condition pose a safety threat to their workplace, the public or themselves? ◯ Yes ◯ No

Do you believe your patient is competent to endorse cheques and direct the use of the proceeds thereof? ◯ Yes ◯ No

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Functional Overlay		
Are the clinical findings proportional to the patient's complaints?	◯ Yes	◯ No
Is the recovery prolonged beyond the expected duration for this given condition?	◯ Yes	◯ No
Do you recommend any further functional evaluation or medical assessment?	◯ Yes	◯ No
Have all test results, consult reports and any pertinent investigative study results been enclosed?	◯ Yes	◯ No

Physician* Information and Signature

Physician* Name	
Address	
Telephone	Specialty
Signature X	Date (yyyy-mm-dd)

By providing this document to the BC Public Service Agency (PSA) or Canada Life the sender is agreeing that they are, or are an employee of, the patient's physician* identified in the form and that this form has been completed by the physician* or an employee of the physician*.

NOTE: If a psychiatric illness is present please complete the Attending Physician* Initial Statement form as well as the psychiatric section in the Psychiatric Condition Statement.

If you have any questions, please call Canada Life toll free at 1-888-292-4111.

PLEASE NOTE THE PATIENT IS RESPONSIBLE FOR ANY CHARGES INCURRED FOR THE COMPLETION OF THIS FORM.

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Psychiatric Condition Statement

Patient's Name	Employee Number

Please provide the appropriate multi-axial diagnosis as described by the most current Diagnostic and Statistical Manual (DSM) using appropriate diagnostic code numbers:

Axis I	Code
	Code
Axis II	Code
	Code
Axis III (Any diagnosis not listed earlier)	Code
	Code
Axis IV	Code
	Code

AxisV	Current GAF	GAF at prior assessment

Date of your last consultation: (yyyy-mm-dd)	Date of the next scheduled visit: (yyyy-mm-dd)

Has the patient been assessed by a psychiatrist or psychologist? ◯ Yes ◯ No

Has a Neuropsychological Assessment or other formal mental status exam been performed or planned? ◯ Yes ◯ No

Please indicate patient's current symptoms manifested and degree of severity:

Is your patient able to perform the following activities?

Daily living	◯ Yes	◯ No	◯ Limited	Travel	◯ Yes	◯ No	◯ Limited
Self-care, hygiene	◯ Yes	◯ No	◯ Limited	Social	◯ Yes	◯ No	◯ Limited
Household chores	◯ Yes	◯ No	◯ Limited	Recreation	◯ Yes	◯ No	◯ Limited

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Psychiatric Condition Statement

Functional Scale where:

Mild Impairment is capable of most useful functioning.

Moderate Impairment is capable of some but not all useful functioning.

Marked Impairment is useful functioning significantly impaired.

Extreme Impairment is incapable of useful functioning.

	Impairment				
Function	None	Mild	Moderate	Marked	Extreme
Comprehend instructions	◯	◯	◯	◯	◯
Perform simple tasks	◯	◯	◯	◯	◯
Maintain attention to detail	◯	◯	◯	◯	◯
Perform and manage multiple tasks	◯	◯	◯	◯	◯
Make responsible, accountable decisions	◯	◯	◯	◯	◯
Work cooperatively with others	◯	◯	◯	◯	◯
Ability to self-supervise	◯	◯	◯	◯	◯
Deal with confrontational situations	◯	◯	◯	◯	◯
Tolerate distracting stimuli	◯	◯	◯	◯	◯

Is this a psychotic episode or are there any psychotic features: ◯ Yes ◯ No

Please explain:

Are the patient's symptoms due to or exacerbated by alcohol or drug abuse? ◯ Yes ◯ No

Please indicate the type, frequency and expected duration of treatment, counselling, therapy, medication prescribed including dosages, start date and any changes.

What is the prognosis?

We ask you provide copies of all pertinent specialists' consultation reports, progress reports, and test results. Your attention to our request for the information is much appreciated and will greatly assist your patient in the application process for this Long Term Disability benefit. If you have any questions, please call Canada Life toll free at 1-888-292-4111.

Physician* Signature X	Date (yyyy-mm-dd)
Name (please print)	Telephone

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PLEASE NOTE THE PATIENT IS RESPONSIBLE FOR ANY CHARGES INCURED FOR THE COMPLETION OF THIS FORM.

Employee Name	Employee Number