

# 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 Doctor's 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 Great West Life Assurance Company's (GWL) 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 GWL in Vancouver.
- Please complete the Attending Physician's 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 Psychological Physician's 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.

Great-West Life Assurance Company  
900 -1075 West Georgia Street  
Vancouver BC V6E 4N4

Toll Free: 1-888-292-4111  
Fax: 1-844-816-1038  
Email: [vancouver.DMSO@gwl.ca](mailto:vancouver.DMSO@gwl.ca)  
Forms available at: [www2.gov.bc.ca/myhr](http://www2.gov.bc.ca/myhr)

Employee Name	Employee Number
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# Attending Physician's 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 Great-West Life Assurance Company (GWL) 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 Name                      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):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Employee Name

Employee Number

## Attending Physician's 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's Initial Statement form as well as the psychiatric section in the Psychological Physician's 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.

Employee Name	Employee Number
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# Attending Physician's Initial Statement Claim for Long Term Disability Benefit

## Return to Work Planning

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

To his or her 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 his or her 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

Employee Name	Employee Number
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## Attending Physician's Initial Statement Claim for Long Term Disability Benefit

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's Name		
Address		
Telephone	Specialty	
Signature	Date (yyyy-mm-dd)	
X		
<p>By providing this document to the BC Public Service Agency (PSA) or Great West Life (GWL) 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.</p>		
<p><b>NOTE: If a psychiatric illness is present please complete the Attending Physician's Initial Statement form as well as the psychiatric section in the Psychological Physician's Statement.</b></p>		

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

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

Employee Name	Employee Number
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Patient's Name				Employee Number			
Please provide the appropriate multi-axial diagnosis as described by the Diagnostic and Statistical Manual Fourth Edition (DSM IV) 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	
Axis V		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
Employee Name				Employee Number			

<p><b>Functional Scale where:</b>  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.</p>					
	<b>Impairment</b>				
<b>Function</b>	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: Please explain:				Yes	No
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?					
<p><b>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 GWL toll free at 1-888-292-4111.</b></p>					
Physician Signature X				Date (yyyy-mm-dd)	
Name (please print)				Telephone	
<p>By providing this document to the BC Public Service Agency (PSA) or Great West Life (GWL) the sender is agreeing that they are, or are an employee of, the <b>patient's</b> physician <b>identified in the form</b> and that this form has been completed by the physician or an employee of the physician.</p>					
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