# UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

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**3A**

## APPLICATION FOR DISABILITY BENEFITS - PHYSICIAN'S STATEMENT

**TO ALLOW US TO MAKE A PROPER ASSESSMENT, PLEASE ANSWER ALL OF THE QUESTIONS IN FULL FAILURE TO DO SO MAY RESULT IN A DELAY OR DENIAL OF BENEFITS**

## CLAIMANT AUTHORIZATION (TO BE COMPLETED BY MEMBER)

Mr. ☐ Ms. ☐ Name _____ SIN _____
(First) (Last)

Address _____
(Number and Street) (City) (Province) (Postal Code)

Phone Number _____

I hereby authorize the release of any information requested with respect to my claim for benefits and understand that any charges made in respect of the completion of this form are my responsibility.

Signature of Claimant _____ Date _____

Signature (if other than Claimant) _____ Date _____

## ATTENDING PHYSICIAN'S STATEMENT

**"Totally Disabled" or "Total Disability"** means the complete inability of an Employee, due to a Physical Condition, to perform ***any gainful occupation*** for which he is reasonably fitted by education, training or experience or for which he may reasonably become so qualified.

For the purposes of this definition, an Employee shall be deemed to continue to be Totally Disabled during the period during which he engages in an approved rehabilitation program or approved rehabilitation employment.

**1. Diagnosis**. (**For Mental Health disorders, please complete Form 3AMN.)**

Primary: _____

Secondary: _____

What prevents the claimant from performing the duties of his/her regular occupation. Please be sure to include all medical restrictions:

_____

_____

_____

Objective findings - **Please attach copies of all relevant diagnostic test results:**_____

_____

**2. Prognosis**

☐ Good ☐ Fair ☐ Poor ☐ Guarded

Comments: _____

_____

Is the Primary diagnosis considered permanent? ☐ Yes ☐ No

## ATTENDING PHYSICIAN'S STATEMENT (continued)

**3. History - A copy of your clinical notes relating to this period of disability is required. Please provide.**

How long has the claimant been your patient? _____

Date symptoms first appeared or accident happened: Year _____ Month _____ Day _____

Date the illness/injury first prevented the claimant from working: Year _____ Month _____ Day _____

Has the claimant ever had the same or a similar illness/injury? ☐ Yes ☐ No ☐ Unknown

If "Yes", please specify diagnosis and dates of treatment: _____

_____

Did the illness/injury arise out of the claimant's employment? ☐ Yes ☐ No

If "Yes", has a Workers' Compensation claim been completed? ☐ Yes ☐ No

Are the claimant's symptoms the result of drug or alcohol abuse? ☐ Yes ☐ No

Is the injury the result of a Motor Vehicle Accident? ☐ Yes ☐ No ☐ Unknown

Current Height: _____ Current Weight: _____

**4. If Pregnancy Related**

What is E.D.C.? Year _____ Month _____ Day _____

Para:_____ Gravida: _____ Baseline Weight:_____ ☐ Increase ☐ Decrease

What current medical restrictions prevent the claimant from working?_____

_____

_____

_____

**5. Treatment Dates**

Date of first visit for this illness/injury: Year _____ Month _____ Day _____

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify)_____

Date of next visit: Year _____ Month _____ Day _____

Date of Hospital Inpatient admission: Year _____ Month _____ Day _____

Date of Discharge: Year _____ Month _____ Day _____

Date of Hospital Outpatient admission: Year _____ Month _____ Day _____

Date of Discharge: Year _____ Month _____ Day _____

Name of Hospital: _____

## ATTENDING PHYSICIAN'S STATEMENT (continued)

**6. Treatment Plan -** Please describe (include start date of treatment; recommended frequency where applicable; surgical procedures and dates of surgery; expected treatment duration).

_____

_____

_____

Are any further tests/consultations expected? ☐ No ☐ Yes. If "Yes", state when and describe:_____

_____

_____

Has the claimant been referred to a specialist or other treating/consulting physicians?

☐ No ☐ Yes. If "Yes", please identify below and provide copies of all relevant consultation reports.

| Name | Specialty | Date Of Referral (yyyy,mm,dd) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list all medications:

| Diagnosis | Med | Dose and Frequency | Start dd/mm/yy | End dd/mm/yy |
|---|---|---|---|---|
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please indicate how any of the above Meds may affect the claimant's ability to perform own occupation: _____

_____

_____

Please **(√)** all of the following that may assist the claimant's recovery:

☐ Weight Loss ☐ Smoking Cessation ☐ Nutritional Counselling ☐ Pain Management

## ATTENDING PHYSICIAN'S STATEMENT (continued)

**7. Return To Work Plans**

a) Has the claimant expressed a desire to return to work? ☐ Yes ☐ No

b) Have you discussed recovery/return to work expectations with the claimant? ☐ Yes ☐ No

c) Expected Return To Work date: Year_____ Month_____ Day _____

e) Under what circumstances could the claimant return to **other** work (in either another occupation or with modified duties), or participate on a gradual return to work program in their own occupation. Please list the restrictions which need to be considered, and the number of hours recommended per week in developing a return to work program.

_____

_____

_____

_____

f) If claimant will not be able to return to his/her regular occupation, would vocational counseling/rehabilitation be of assistance? ☐ Yes ☐ No

Please indicate what restrictions need to be considered in developing such a plan and when the assistance could start. _____

_____

_____

_____

Name of Attending Physician (Please Print) _____

Specialty _____

Address _____
(Street) (City) (Province) (Postal Code)

Signature of Physician _____ Date _____

Telephone _____ Fax _____

Affix Office Stamp Here: