SASKATCHEWAN BLUE CROSS®

CLAIMANT'S STATEMENT OF CONTINUING DISABILITY

Instructions:

a) Answer all questions fully and sign certificate below.
b) Have the reverse side of this form completed by your attending physician.
c) Forward the completed form to your employer.

1. Name and mailing address of employee Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑	2. Policy No. _____ Identification No. _____
3. Name of Employer:	
4. Confined to ❑ House? ❑ Hospital? (give name, address and details)	
5. Describe any change in your condition since the last report.	6. Give the particulars of your daily routine or how you spend your time.
7. When did you first return to work? *(day, month, year)* _____ **or** When do you expect to return to work? *(day, month, year)* _____	
8. Names and addresses of attending physicians including any other physician consulted since last report.	9. If you have visited your place of employment since the last report, give dates and purpose of visit.

10. Have you applied or are you receiving benefits or are you eligible to receive benefits under the following plans?

	Yes	No	Date of Application *(Day) (Month) (Year)*	Details
Canada / Quebec Pension Plan	❑	❑		
Workers' Compensation	❑	❑		
Employment Insurance Commission	❑	❑		
Other Government Plan	❑	❑		
Group Income Replacement Plan	❑	❑		
Other remuneration from any employer	❑	❑		

Employer: _____ Date: _____

Signature: _____ Date: _____

I hereby certify that the above information is correct to the best of my knowledge and belief.

I understand that the personal information provided herein, as well as any other personal information currently held, or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, any Saskatchewan Health Agency including the Saskatchewan Prescription Drug Plan, the policy holder or certificate holder of any policy under which I am a participant, and other third parties when required to administer the benefits outlined in my policy.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Saskatchewan Blue Cross' privacy policies, I can contact Saskatchewan Blue Cross at www.sk.bluecross.ca or 1-800-USE-BLUE should I have questions as to the collection, use of or disclosure of my personal information.

I authorize Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada to collect, use and disclose the personal information as described above.

Dated at _____ this _____ day of _____ 20 _____

_____ _____
Signature of Claimant Address Postal Code

_____ _____
Signature of Witness Address Postal Code

Attending Physician's Supplementary Statement

Instructions:
a) Please print.
b) Any charge for completing this form is the patient's responsibility.

Patient's Name

1. Diagnosis of present condition

2. a) Indicate complications or new independent conditions, such as surgery, which may prolong the absence from work.

b) Date of hospital admission
_____ / _____ / _____
(Day) (Month) (Year)

Date of discharge
_____ / _____ / _____
(Day) (Month) (Year)

c) Date of latest attendance
_____ / _____ / _____
(Day) (Month) (Year)

3. Cardiac *(if applicable)*

A. Functional Capacity (American Heart Association)

❑ Class 1 *(no limitation)* ❑ Class 2 *(slight limitation)* ❑ Class 3 *(marked limitation)* ❑ Class 4 *(complete limitation)*

B. Blood pressure *(last visit)*

Systolic | Diastolic

4. a) Have you been actively supervising this patient's care?

❑ Yes, state frequency of visits ❑ Weekly ❑ Monthly ❑ Other, specify

❑ No, please comment _____

b) Nature of treatment (including surgery, physiotherapy and medications prescribed, if any)

c) To your knowledge is patient following recommended treatment program?

❑ Yes ❑ No, please comment

5. a) If patient was referred to you, give name of referring physician

b) If you have referred patient to a specialist, give name(s) of physicians

6. a) To the best of your knowledge, is the patient presently unable to work at own occupation?

❑ Yes, give approximate date when patient should be able to return to work

❑ Estimated number of weeks before possible return

or

❑ No, give date patient could have returned to work *(day, month, year)*

b) How long was or will patient be able to work part-time at own occupation?

From *(day, month, year)* | To *(day, month, year)*

c) Is patient a suitable candidate for rehabilitation program?

❑ Yes ❑ No

7. Remarks - Please provide comments and further details which you feel would be helpful

Subjective symptoms

Objective symptoms (including results of current x-rays, ekg's or laboratory date and any relevant clinical findings)

Please advise how present condition affects patient's ability to work *(for example: restrictions, limitations, proposed surgery, etc.)*

Blue Cross Life Insurance Company of Canada underwrites all life and disability income benefits.

Name of physician (please print) | Specialty | Telephone No. ( )

Address *(number, street, city, province, postal code)*

Signature | Date *(day, month, year)*