P.O. Box 4241, Station A
Toronto, ON M5W 5R3
ivari.ca

Initial Attending Physician's Statement

Notice regarding collection, use and disclosure of personal information – (Privacy Notice)

ivari's Privacy Policy, available at **ivari.ca,** tells you how ivari will handle your personal information as an Insured and/or Claimant. It also tells you about your rights and choices.

In summary:

ivari uses your personal information for the following purposes:

- Verifying your identity;
- Evaluating any forms you submit about the insurance policies you have in place with ivari;
- Administering and servicing the policy;
- Supporting business operations necessary for us to service the policy;
- Conducting investigations and analyzing claims; and
- Complying with our legal and regulatory obligations (such as tax reporting, compliance with anti-money laundering and anti-terrorist financing laws, and prudential and market conduct laws) and/or any legal or regulatory orders (for example, a court order, subpoena) against ivari.

When required as part of our claims analysis, we may also collect your personal information from external sources such as health care facilities or providers, investigative agencies and/or consumer and credit reporting agencies, and others.

When required, ivari may share your personal information with trusted third parties, including service providers retained by ivari to assist in administering ivari policies, ivari's reinsurers; your financial institution, your independent insurance advisor and their supporting associates, market intermediaries, your beneficiaries and assignees, your family physician or treating medical practitioner and other insurance companies to whom a claim for benefits may be submitted.

It is possible that your personal information may be transferred, stored, handled, or processed outside your jurisdiction and that authorities in those jurisdictions may have access to it.

In some cases, you have a **right to withdraw consent** to the use and sharing of your personal information. You also have the **right to see and correct** the information we have about you, and to **obtain information about any fully automated decisions** we make using your information. Mail your written request to: **Chief Privacy Officer, ivari, 200-5000 Yonge Street, Toronto, Ontario M2N 7E9 or email: privacyoffice@ivari.ca.**

You can see ivari's full Privacy Policy online at ivari.ca. Please make sure you read it carefully so that you understand it in full. Please note that we may update this Privacy Policy from time to time.

CONSENT REQUIRED FOR THIS FORM AND POLICY

The following consents are required to proceed with and submit this form to ivari:

1. I give my consent to the collection, use and disclosure of my personal information as described in the **Privacy Notice** and in ivari's Privacy Policy on **ivari.ca.**
2. I authorize ivari to collect my personal information from third parties for the purposes described in and in accordance with ivari's Privacy Policy.
3. If I am giving my consent on behalf of one or more minor Insured(s) (under the age of 18 years in Quebec or under the age of 16 years in all other provinces) to the points above, then I represent that I have authority to consent on behalf of the minor Insured(s).

Signature of **Insured** _____ Signature of **Claimant** _____

Declaration and Authorization

Claimant's Certification: The statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, the policy can be voided, payment of benefits denied and past claims payments recovered. I hereby agree to refund to ivari, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from ivari. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

Insured name _____ Signature of Insured _____ Date (DD/MM/YYYY) _____

Claimant name _____ Signature of Claimant _____ Date (DD/MM/YYYY) _____

Relationship to the Insured _____

1 Insured Information

THIS PART OF THE FORM SHOULD BE COMPLETED BEFORE THE PHYSICIAN COMPLETES SECTION 2

Instructions to the Insured:

- Please complete, sign and date Section 1.
- Ask your physician to complete Section 2.

Please note that you, the Insured, are responsible for the cost of completing this form.

I understand that the information collected on this claim form, and otherwise in connection with my claim, is required by ivari, its reinsurers and authorized administrators (the "Insurer") for the purposes of investigation and claim analysis.

Insured's name _____

Policy number(s) _____ Date of birth _____ (DD/MM/YYYY) Height (cm) _____ Weight (kg) _____

Occupation _____ Employer (if applicable) _____

2 Physician's Report

Instructions to the Physician:

- Please complete, sign and date Section 2.
- Please enclose copies of chart notes, consultation reports, investigations and test results that relate to your patient's claim for disability*.

To assist us in adjudicating your patient's claim, we kindly ask that you complete this statement as thoroughly as possible. *ivari* will use the information in this form to determine your patient's eligibility for disability benefits.

Please be assured that the information, including the medical records requested will be treated confidentially.

Any information provided by you to ivari regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of your patient or harm to a third party.

We thank you in advance for your cooperation and please note that the patient is responsible for any charges incurred in the completion of this form.

Documents Required* (as applicable)

Copies of all:
- investigation reports
- laboratory data
- consultation reports
- clinical notes
- hospital admission, histories and discharge summaries

*ivari will disburse up to a $75.00 administration fee for photocopying upon receipt of your patient's records. If this amount is unreasonable due to the size of your patient's chart, please call 1-855-806-5057 and ask for the claims department to request an alternative fee.

DIAGNOSIS

Primary _____

_____

_____

Secondary _____

_____

_____

Date of disability: (DD/MM/YYYY) _____

Symptoms – Please describe the symptoms, including severity, frequency, and duration.

_____

_____

_____

Physical Findings – Please describe the clinical findings in relation to the claimed disability.

_____

_____

_____

MEDICAL HISTORY

1. What was the date of the patient's first appointment for the claimed disability? Date (DD/MM/YYYY) _____
2. What was the date of the patient's latest appointment? Date (DD/MM/YYYY) _____
3. How often are the patient's appointments?
   ○ Weekly ○ Bi-weekly ○ Monthly ○ Other (Please specify): _____
4. Did you recommend that the patient stop work?
   ○ Yes ○ No If ***"yes"*** as of what date? Date (DD/MM/YYYY) _____
5. Was the patient's disability caused by an accident?
   ○ Yes ○ No If ***"yes"*** give details and the date of the accident. Date (DD/MM/YYYY) _____

   _____

   _____
6. When did the symptoms first appear? Date (DD/MM/YYYY) _____
7. Has the patient ever had a similar or related condition?
   ○ Yes ○ No If ***"yes"*** state when and describe the condition. _____

   _____
8. Is the condition due to injury or illness caused by employment?
   ○ Yes ○ No If ***"yes"*** give details. _____

   _____
9. Has the patient had any licences or certifications restricted or revoked (e.g. driver's licence, professional certification)?
   ○ Yes ○ No If ***"yes"*** give details. _____

   _____
10. Is the condition due to or related to pregnancy?
    ○ Yes ○ No If ***"yes"*** give date of confinement. Date (DD/MM/YYYY) _____

11. Investigations

    Describe the results of any examinations, laboratory tests, X-rays, ECGs, and all other investigations related to the patient's disability. Please include copies of test results and reports.

12. Precipitating chronological events:

13. Are work related issues contributing to your patient's condition?

14. Familial risk factors:

15. Complicating factors:

    Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution:

    ☐ Workplace issues ☐ Alcohol/Drug abuse ☐ Financial/Legal Problems
    ☐ Coping skills ☐ Physical/Mental condition ☐ Other issues
    ☐ Social/Family issues ☐ Personality/Motivation

    Please comment below:

PHYSICAL IMPAIRMENT IF APPLICABLE

☐ Class 1 – No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
☐ Class 2 – Medium manual activity. (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)
☐ Specific limitation(s)? (bending, lifting, etc.) _____

CARDIAC IF APPLICABLE

1. What is the functional capacity (American Heart Association)? If Class 3 or 4, please include a copy of any stress tests or echocardiograms.

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

2. What is the latest blood pressure reading for the patient? _____ Date (DD/MM/YYYY) _____

MENTAL/NERVOUS IMPAIRMENT IF APPLICABLE

1. What symptoms is this patient displaying that indicate a mental impairment exists?

2. Has there been a psychiatric referral? ○ Yes ○ No If ***"yes"***, Name of Psychiatrist

3. What is the diagnos(es) using the DSM V?

   Axis I

   Axis II

   Axis III

   Axis IV

   Axis V

   Remarks

PROGRESS

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?

   ○ Recovered ○ Improved ○ Unchanged ○ Retrogressed

2. What is the patient's current status?

   ○ Ambulatory ○ House confined ○ Bed confined ○ Hospital confined

3. Has the patient achieved maximum medical recovery? ○ Yes ○ No If ***"no"***, how soon do you expect further improvement?

4. What is your prognosis, please specify any expected improvement or deterioration and time frames.

5. How is your patient limited from performing his/her work? What prevents a return to full or partial duties?

6. What are the patient's restrictions (what the patient SHOULD NOT do) and why?

7. Can the patient return to part-time or modified work? ○ Yes ○ No If ***"yes"***, please give details.

_____

_____

_____

8. What is your patient's expected return to work date?

   Full-time: Date (DD/MM/YYYY) _____ Part-time: Date (DD/MM/YYYY) _____

9. Please describe any factors not mentioned above that may affect your patient's ability to return to work (such as family issues, stress in the workplace or abuse of medication, alcohol or any other substances).

_____

_____

_____

TREATMENT

1. Was the patient hospitalized?

   ○ Yes ○ No If ***"yes"***, name of hospital/facility _____

   From (DD/MM/YYYY) _____ To (DD/MM/YYYY) _____

2. Was surgery performed?

   ○ Yes ○ No If ***"yes"***, please complete:

DATE (DD/MM/YYYY)	TYPE OF SURGERY

3. If medication is being administered, please describe below:

MEDICATION	DOSAGE AND FREQUENCY	DATE STARTED (DD/MM/YYYY)	DATE STOPPED (DD/MM/YYYY)	RESPONSE
a)				
b)				
c)				
d)				

4. Was psychotherapy given? ○ Yes ○ No If ***"yes"***, give frequency, duration and response.

_____

_____

5. Was physiotherapy/chiropractic treatment given? ○ Yes ○ No If ***"yes"***, give frequency, duration and response.

_____

_____

6. Has the patient been referred to a rehabilitation program? ○ Yes ○ No If ***"yes"***, indicate:

NAME OF PROGRAM	DATE ATTENDED (DD/MM/YYYY)	DURATION

7. What other treatments were given? What was the response? Please list any side effects.

8. What further treatment is being considered?

9. Have you been actively supervising this patient's care? ○ Yes ○ No If ***"no"***, explain:

10. Please give the names, specialties and appointment dates of all other treating Health Care Providers.

NAME OF HEALTH CARE PROVIDER	SPECIALTY	APPOINTMENT DATES (DD/MM/YYYY)S

COOPERATION AND MOTIVATION

1. Please comment on how cooperative and compliant the patient has been with the treatment plan.

2. Additional Information
   In your opinion, is the patient capable of handling his/her own financial affairs? ○ Yes ○ No

PHYSICIAN'S REPORT

1. Remarks
   Is there any other information you wish to add that will give us a better understanding of your patient's condition?

2. Attending Physician Information

Name			
Address			
City	Province/territory/state	Country	Postal/zip code
Telephone Number	Email address		
Specialty (please give details).			

3. Attending Physician's Declaration and Signature

I certify that the statements on this form are true, complete and to the best of my knowledge.

Signature _____ Date (DD/MM/YYYY) _____

Please mail this form to:

ivari
ATTN. ivari Claims Department
P.O. Box 4241, Station A
Toronto, ON M5W 5R3

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