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

Attending Physician's Statement of Continuing Disability

Instructions to the Insured:
- Please complete, sign and date Section 1.
- Ask your physician to complete Section 2.

Please note that the Insured is responsible for the cost of completing this form.

Instructions to the Physician:
- Please complete, sign and date Section 2.

The provider of these benefits, ivari is committed to keeping your information confidential.

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.

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

1 General Information

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

Insured's name	Date of birth (DD/MM/YYYY)	Policy Number(s)
Email address	Occupation prior to disability	

PLEASE NOTE THAT THE INSURED IS RESPONSIBLE FOR THE COST OF COMPLETING THIS FORM.

2 Physician's Report

(since your last report)

To assist us in adjudicating your patient's claim, we kindly ask that you complete this statement as thoroughly as possible.

Please be assured that the information, including medical records 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.

DIAGNOSIS

If applicable, please use DSM V terminology.

Primary _____

Secondary _____

Symptoms

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

Examination Findings

Please describe the clinical findings in relation to the claimed disability.

Investigations

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

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

PROGRESS

1. Which of the following best describes the progress of the patient's condition?
   ○ Recovered ○ Improved ○ Unchanged ○ Retrogressed
2. Has the patient achieved maximum medical recovery? ○ Yes ○ No
3. What is your prognosis, specifying any expected improvement or deterioration and time frames.

   _____

   _____
4. What prevents a return to full or partial duties?

   _____

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

   _____

   _____

   _____
6. What is your patient's expected return to work date?
   Full-time: Date: (DD/MM/YYYY) _____ Part-time: Date: (DD/MM/YYYY) _____
7. 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. What was the date of the patient's latest appointment? Date: (DD/MM/YYYY) _____
2. How often are the patient's appointments? _____
3. Was the patient hospitalized? ○ Yes ○ No
   If ***"Yes"***, name of hospital/facility _____
   From: (DD/MM/YYYY) _____ To: (DD/MM/YYYY) _____
4. Was surgery performed? ○ Yes ○ No If ***"Yes"***, please provide date(s) and type of surgery.

   _____

   _____

   _____

   _____
5. If medication is being administered, please describe below:

MEDICATION	DOSAGE AND FREQUENCY	DATE STARTED (DD/MM/YYYY)	DATE STOPPED (DD/MM/YYYY)	RESPONSE

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

7. Has the patient been referred to a rehabilitation program? ○ Yes ○ No
   If ***"Yes"*** indicate name of program, dates attended and duration.

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

9. What further treatment is being considered?

10. Have you been actively supervising this patient's care? ○ Yes ○ No If ***"No"*** please explain.

11. 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)

OTHER INSURANCE

Please list any other insurance carrier(s) or government plans you completed forms for your patient:

COOPERATION AND MOTIVATION

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

REMARKS

Please list any other information you wish to add that will give us a better understanding of your patient's condition.

ATTENDING PHYSICIAN'S DECLARATION, SIGNATURE AND INFORMATION

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

Signature: _____ Date: (DD/MM/YYYY) _____

Name			Specialty
Address			Apt./suite #
City	Province/territory/state	Country	Postal/zip code
Telephone Number	Email address		

Please return the completed form by mail to the ivari Claims Department at the address below or by using our ***Send documents*** tool on **ivari.ca**.

P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-855-806-5057 • **claimsdepartment@ivari.ca**

The fastest and easiest way to send us your completed and signed forms is through our online tool, *Send documents* on ivari.ca. By using this tool, forms are sent instantly and securely.

SAVE PRINT CLEAR