Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

According to your region, please submit the completed form to:

Québec
PO Box 790, Station B
Montréal, Québec H3B 3K6
Fax: 1-877-799-6691
Email: disabilitylife@inalco.com

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7
Fax: 1-877-781-1583
Email: disabilityclaims@inalco.com

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Attending Physician's Statement - Confirmation of Ongoing Long Term Disability

Plan Member/Employee Information and Consent (To Be Completed by Plan Member)

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (Include Area Code)	Cell Phone # (Include Area Code)
Claim #	Plan Contract Number	Plan Member Certificate Number
Address (Street, City, Province, Postal Code)		Date of Birth (dd/mm/yyyy)

I hereby authorize the release of medical and health information in my file to _____(the insurance company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

_____ _____
Plan Member/Employee Signature Date of Consent (dd/mm/yyyy)

Attending Physician's Statement (To Be Completed by Physician)

1. Please indicate if there have been any changes in the patient's condition since the last report:
   Improvement ☐ Retrogression ☐ No Change ☐
   Please elaborate: _____

2. Do you anticipate any improvement in the patient's condition in the foreseeable future?
   Yes ☐ No ☐
   Please elaborate: _____

3. Are there any plans to change or augment the current treatment regime?
   Yes ☐ No ☐
   If yes, please elaborate: _____

4. In your opinion, is the patient competent to manage his/her affairs?
   Yes ☐ No ☐
   Comments: _____

Please attach copies of any of the following performed or received since your last report:
- **Test results / investigations / consultation reports**

If not attached, we will assume that none were performed or received.

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (Please Print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (Include Area Code)	Fax # (Include Area Code)	
Signature	Date (dd/mm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.