

GROUP  
INSURANCE



F54-381A(16-06)

# Disability Claim Form

Initial Request



INVESTED IN YOU.

iA Financial Group is a business name and trademark of  
Industrial Alliance Insurance and Financial Services Inc.

ia.ca

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

**Quebec**

PO Box 800, Station Maison de la Poste  
Montreal, Quebec H3B 3K5

**All Other Provinces**

522 University Avenue, Suite 400  
Toronto, Ontario M5G 1Y7

## INSTRUCTIONS

In order to properly complete the form, each party should follow the instructions below.

### POLICYHOLDER (Employer or plan administrator)

1. Please complete the "Policyholder's Statement" and ensure that you answer all questions to avoid file review delays.
2. For long-term disability or waiver of premium without short-term disability coverage requests, Industrial Alliance Insurance and Financial Services Inc. must receive the duly completed form signed by all parties **6 to 8 weeks before the waiting period expires.**

### MEMBER

1. Please complete the "Member's Statement" and ensure that you answer all questions to avoid file review delays. Don't forget to sign the "Member Confirmation/Authorization" in Part 7.
2. Please ensure that your attending physician completes the medical declaration that applies to your condition (physical and/or psychological). You must also complete the "Member Identification" section AND you must sign the "Member Authorization" at the top of the physician's declaration.
3. Please enclose a photocopy of the benefit statement from any government plan under which you are receiving benefits (Régie des rentes du Québec, Canada Pension Plan, workers' compensation, auto insurance, victim of criminal act compensation, etc.)
4. Attach a copy of all correspondence received from any government plan mentioned in number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of the file.

Note:

- a) It is your responsibility to pay any fees that may be incurred to have this form completed by your attending physician.
- b) During the course of a disability, it is very important to read the comments provided on your benefit cheque stubs. These comments are to inform you of any decisions that have been made as well as to request any additional information that may be required in case of an extended disability.
- c) Please return the entire document to the applicable address above. Do not detach any pages.

### ATTENDING PHYSICIAN

1. Please complete the medical declaration that applies to the condition of your patient (physical and/or psychological) ensuring that you answer all questions to avoid file review delays.
2. Please attach any other documentation pertinent to the analysis of the request (test results of various examinations carried out and specialist consultation reports) to the form.



**PART 1 – MEMBER INFORMATION (Continued)**

6. Date hired 

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 Certificate effective date 

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 Last day at work 

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 7. Date of return to work (if applicable) 

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 Full-time  Part-time  Regular job   
 8. Primary reason for disability: Illness  Accident outside of work  Accident at work   
 Motor vehicle accident  Occupational illness   
 9. On the date the disability commenced, was the employee: On vacation  Laid off  On paid leave  On unpaid leave   
 On disciplinary suspension without pay   
 On disciplinary suspension with pay  Other  \_\_\_\_\_

**PART 2 – MEMBER'S WORK SCHEDULE AND EARNINGS INFORMATION**

1. Indicate the hours of work in a normal week: \_\_\_\_\_ For an irregular schedule, indicate the daily schedule.  
 Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_ Sunday \_\_\_\_\_  
 2. Gross salary prior to date of disability: \$ \_\_\_\_\_ Annual  Monthly  Biweekly  Weekly  Other   
 for \_\_\_\_\_ number of hours Annual  Monthly  Biweekly  Weekly  Other   
 3. Tax credits: Federal (TD1) \_\_\_\_\_ Provincial (TPD1) \_\_\_\_\_  
 4. Has or will the member receive other amounts apart from the disability insurance benefits during the disability period? Yes  No   
 Specify: Vacation  Maternity leave  Employment Insurance (HRSDC)  Sick leave  Statutory holiday   
 Other  \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 From \_\_\_\_\_ to \_\_\_\_\_  
 5. Has the member applied or will be applying for benefits from any of the organizations indicated below? Yes  No   
 If so, please specify:  
 Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization   
 Société de l'assurance automobile du Québec (SAAQ) or other similar organization   
 Human Resources and Social Development Canada (HRSDC)   
 Régie des rentes du Québec (RRQ)  Disability pension  Retirement pension   
 Canada Pension Plan (CPP)  Disability pension  Retirement pension   
 Other (specify)  \_\_\_\_\_  
 6. If the member is already receiving benefits from one of the sources above, please indicate the amount: \$ \_\_\_\_\_  
 Attach a copy of the letter of acceptance and the most recent cheque stub, if applicable.  
 7. If necessary, are you able to provide a job: with a gradual return to work?  with light duties?   
 8. Please indicate any other comments relevant to this claim.

\_\_\_\_\_  
 \_\_\_\_\_

I certify the accuracy of the information above.

Authorized signature \_\_\_\_\_ Date 

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

|  |                                  |
|--|----------------------------------|
| <b>Quebec</b>                          | <b>All Other Provinces</b>       |
| PO Box 800, Station Maison de la Poste | 522 University Avenue, Suite 400 |
| Montreal, Quebec H3B 3K5               | Toronto, Ontario M5G 1Y7         |

**Type of claim:** Short-Term Disability  Long-Term Disability  Waiver of Premium

**MEMBER'S STATEMENT**

TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

**PART 1 – IDENTIFICATION**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Sex Female  Male

Policy no. [ ] [ ] [ ] [ ] [ ] [ ] Social Insurance Number [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Certificate no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Date of birth [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Occupation \_\_\_\_\_ Language French  English

**PART 2 – REASON FOR THE CLAIM**

- Accident. If the sick leave was the result of an accident, indicate:
  - Place of the accident: Home  Work  Elsewhere  (specify) \_\_\_\_\_
  - Date of the accident [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Circumstances \_\_\_\_\_
  - If a car accident, specify whether you were: Driver  Passenger  If not a Quebec resident, please submit the police report.
- Is the period of disability due to work-related problems? No  Yes  Specify \_\_\_\_\_

**PART 3 – OCCUPATION**

Date hired [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] When did you become unable to work? Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

- Explain how your condition is preventing you from working.  
\_\_\_\_\_  
\_\_\_\_\_
- Describe the duties of your job that you can no longer perform.  
\_\_\_\_\_  
\_\_\_\_\_
- When you stopped working, were you working anywhere else (second job)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART 4 – CURRENT SITUATION**

- Are you confined to your home? No  Yes   
 Confined to your bed? No  Yes   
 Hospitalized? No  Yes
- Please describe all your symptoms including severity and frequency.  
\_\_\_\_\_  
\_\_\_\_\_
- Describe your current activities of daily living since going on sick leave.  
\_\_\_\_\_  
\_\_\_\_\_

**PART 5 – INCOME FROM OTHER SOURCES**

Indicate if you have applied or will be applying for benefits from any of the following sources:

- Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization No  Yes  Date 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |
- Société de l'assurance automobile du Québec (SAAQ) or other similar organization No  Yes  Date 

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- Human Resources and Social Development Canada (HRSDC) No  Yes  Date 

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- Régie des rentes du Québec (RRQ) Disability pension  Retirement pension  No  Yes  Date 

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- Canada Pension Plan (CPP) Disability pension  Retirement pension  No  Yes  Date 

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- Other (specify) \_\_\_\_\_ Date 

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If you have already applied for benefits, please provide a copy of all correspondence, including the decision, if applicable.

**PART 6 – PHYSICIANS AND HISTORY**

1. Name of your attending physician \_\_\_\_\_ Date of initial visit 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |

  
Address \_\_\_\_\_
2. Have you been hospitalized for this medical condition? No  Yes  Date 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |

  
Name of hospital \_\_\_\_\_
3. When did your symptoms start? \_\_\_\_\_
4. When did you first consult a physician for this medical condition? \_\_\_\_\_
5. Have you ever had a similar illness or injury before? No  Yes  Date 

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| Y | M | D |
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6. Would you be able to return to work gradually? No  Yes
7. Has your attending physician prescribed medication? No  Yes  If so, are you taking it regularly? No  Yes
8. List all the physicians who have treated you in the last two years.

| Illness | Consultation or treatment date | Treatment prescribed, medication, other | Name and address of physician |
|---------|--------------------------------|---|-------------------------------|
|         |                                |   |                               |
|         |                                |   |                               |
|         |                                |   |                               |

**PART 7 – MEMBER CONFIRMATION/AUTHORIZATION**

I CONFIRM that the statements provided in the Member's Statement and all statements provided in any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge. I AGREE that all such statements form the basis for any benefits approved as a result of this claim.

I HEREBY AUTHORIZE:

- (i) Any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (the Company), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim;
- (ii) The Company to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and
- (iii) The Company and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

A photocopy of this Confirmation/Authorization shall be as valid as the original.

This Confirmation/Authorization is valid only for this disability claim.

Member's signature \_\_\_\_\_ Date 

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Address \_\_\_\_\_

Postal code 

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 Home 

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 Work 

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**PART 2 – LIMITATIONS AND RESTRICTIONS**

- 1. What are your patient's current limitations (what he/she cannot do)? \_\_\_\_\_
- 2. What restrictions are currently placed on your patient (what he/she should not do)? \_\_\_\_\_
- 3. Is the patient able to attend his/her affairs, particularly the endorsement of cheques? No  Yes

**PART 3 – TREATMENT**

- 1. Medication (name and dosage): \_\_\_\_\_
- 2. Medication strategies:
  - Progressive increase \_\_\_\_\_
  - Potentialization \_\_\_\_\_
  - Combinations \_\_\_\_\_
  - Medication changes \_\_\_\_\_
- 3. Is the patient consulting: Psychiatrist? No  Yes  Social worker? No  Yes   
 Psychologist? No  Yes  Other healthcare provider? No  Yes   
 If yes, name of the healthcare provider: \_\_\_\_\_
- 4. Hospitalization: From 

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 Name of hospital \_\_\_\_\_

**PART 4 – FOLLOW-UP AND PROGNOSIS**

- 1. Date of first consultation for this disability: 

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 Starting date of disability: 

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 Next consultation: 

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- 2. Dates of other consultations: 

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 Follow-up frequency: \_\_\_\_\_
- 3. Will the patient be referred to a psychiatrist? No  Yes  Name of physician: \_\_\_\_\_
- 4. Approximate duration of disability: Number of weeks \_\_\_\_\_ or number of months \_\_\_\_\_ or undetermined   
 or date of return to work: 

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- 5. When will your patient be fit to return to work? 

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 Part-time  Full-time  If gradual return  please explain why: \_\_\_\_\_
- 6. Recommended return to work plan Program start date 

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 Week 1 \_\_\_\_\_ days a week Date 

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 Week 3 \_\_\_\_\_ days a week Date 

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 Week 2 \_\_\_\_\_ days a week Date 

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 Week 4 \_\_\_\_\_ days a week Date 

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**PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN**

- 1. Last and first name \_\_\_\_\_ Telephone 

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- 2. Address \_\_\_\_\_ Fax 

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- 3. General practitioner  Specialist  Other  Specify: \_\_\_\_\_  
 Signature \_\_\_\_\_ Date 

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**NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.**



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

|   |  |
|---|--|
| <b>Quebec</b><br>PO Box 800, Station Maison de la Poste<br>Montreal, Quebec H3B 3K5 | <b>All Other Provinces</b><br>522 University Avenue, Suite 400<br>Toronto, Ontario M5G 1Y7 |
|---|--|

**Type of claim:** Short-Term Disability  Long-Term Disability  Waiver of Premium

**MEMBER IDENTIFICATION (The member must complete this section)**

Last name \_\_\_\_\_ First name \_\_\_\_\_

Policy no. \_\_\_\_\_ Social Insurance Number \_\_\_\_\_ Certificate no. \_\_\_\_\_

Date of birth \_\_\_\_\_  
Y M D

**MEMBER AUTHORIZATION**

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (the Company), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim.

A photocopy of this Authorization shall be as valid as the original.

This Authorization is valid only for this disability claim.

Member's signature \_\_\_\_\_ Date \_\_\_\_\_  
Y M D

Address \_\_\_\_\_

Postal code \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT – PHYSICAL ILLNESS**

Please print and give to the patient

**PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST**

**PART 1 – DIAGNOSIS**

1. Primary: \_\_\_\_\_

2. Secondary: \_\_\_\_\_

3. Complications: \_\_\_\_\_

4. For the illnesses or associated symptoms diagnosed, has the patient previously:  
 received medical treatments  consulted another physician  taken medication  been hospitalized   
 undergone examinations  Specify the periods: \_\_\_\_\_

5. a) Is the disability related to the specific risks of this patient's job?  
 No  Yes  If so, explain: \_\_\_\_\_

b) Is the disability related to: Accident  Illness  Work accident  Occupational illness   
 Motor vehicle accident  Date of the event \_\_\_\_\_  
 Y M D

c) Pregnancy No  Yes  Expected date of delivery \_\_\_\_\_  
 Y M D

Preventive leave No  Yes  Start date \_\_\_\_\_  
 Y M D

6. Describe the functional limitations that prevent the patient from carrying out professional duties or usual daily activities.

| At the beginning of disability | Date: | Currently |
|--------------------------------|-------|-----------|
|                                |       |           |
|                                |       |           |
|                                |       |           |

Height: \_\_\_\_\_ m Weight: \_\_\_\_\_ kg Right-handed  Left-handed

**PART 2 – LIMITATIONS AND RESTRICTIONS**

1. What are your patient's current limitations (what he/she cannot do)? \_\_\_\_\_
2. What restrictions are currently placed on your patient (what he/she should not do)? \_\_\_\_\_
3. Cardiac status (if related to the disability):
  - a) Functional capacity (American Heart Association) Class I (no limitation)  Class II (slight limitation)   
Class III (marked limitation)  Class IV (severe limitation)
  - b) Blood pressure (last visit) Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_
  - c) Is the patient able to attend his/her affairs, particularly the endorsement of cheques? No  Yes

**PART 3 – TREATMENT**

1. Medication (name and dosage): \_\_\_\_\_
2. Has the patient undergone or will undergo:
  - a) Examinations or tests No  Yes  Specify: \_\_\_\_\_
  - b) Surgery No  Yes  Day surgery  Type: \_\_\_\_\_ Date: 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |

  
Surgical procedure: \_\_\_\_\_
  - c) Other treatments? No  Yes  Specify: \_\_\_\_\_
  - d) Hospitalization From 

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 to 

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Name of hospital: \_\_\_\_\_
  - e) A short stay under observation (number of hours): \_\_\_\_\_

**PART 4 – FOLLOW-UP AND PROGNOSIS**

1. Date of first consultation for this disability: 

|   |   |   |
|---|---|---|
| Y | M | D |
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 Starting date of disability: 

|   |   |   |
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| Y | M | D |
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Next consultation: 

|   |   |   |
|---|---|---|
| Y | M | D |
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2. Dates of other consultations: 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |

 Follow-up frequency: \_\_\_\_\_
3. Referral to another physician: No  Yes  Name of physician: \_\_\_\_\_  
Speciality: \_\_\_\_\_
4. Approximate duration of disability: Number of weeks \_\_\_\_\_ or number of months \_\_\_\_\_ or undetermined   
or date of return to work: 

|   |   |   |
|---|---|---|
| Y | M | D |
|   |   |   |
5. When will your patient be fit to return to work? 

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|---|---|---|
| Y | M | D |
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Part-time  Full-time  If gradual return  please explain why: \_\_\_\_\_
6. Recommended return to work plan Program start date 

|   |   |   |
|---|---|---|
| Y | M | D |
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Week 1 \_\_\_\_\_ days a week Date 

|   |   |   |
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| Y | M | D |
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 Week 3 \_\_\_\_\_ days a week Date 

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| Y | M | D |
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Week 2 \_\_\_\_\_ days a week Date 

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| Y | M | D |
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 Week 4 \_\_\_\_\_ days a week Date 

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| Y | M | D |
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**PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN**

1. Last and first name \_\_\_\_\_ Telephone 

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2. Address \_\_\_\_\_ Fax 

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3. General practitioner  Specialist  Other  Specify: \_\_\_\_\_  
Signature \_\_\_\_\_ Date 

|   |   |   |
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| Y | M | D |
|   |   |   |

**NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.**