SUTTON
SPECIAL RISK

33 Yonge Street Suite 400
Toronto, Ontario M5E 1G4
Phone: (416) 366-2223
Fax: (416) 366-4608
claims@suttonspecialrisk.com

Proof of Total Disability - Physician's Statement

Please complete in block letters and give to the patient. The insured must pay the fees requested to complete this form.

A - STATEMENT

Employee Name		Policy Number	
Telephone Number		Date of Birth (YYYY/MM/DD)	

Mental Condition
Is the patient competent to endorse cheque and direct the use of the proceeds thereof?

B - DIAGNOSIS

Primary

Secondary

Complications

For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments ☐ consulted another physician ☐ taken drugs ☐ been hospitalized ☐ undergone examinations

Specify the periods: _____

Is the disability related to:

☐ an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident

Date of the event (YYYY/MM/DD) _____

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

At the beginning of the disability (YYYY/MM/DD):	Currently:

C - TREATMENT

Drugs - name - dosage:

Has the patient undergone or will undergo:

a) examinations or tests ☐ Yes ☐ No Specify: _____

b) surgery ☐ Yes ☐ No Day Surgery ☐ Type: _____

Surgical procedure: _____ Date (YYYY/MM/DD): _____

c) other treatments ☐ Yes ☐ No

d) hospitalization: From _____ To _____ Name of hospital: _____

e) a short stay under observation ☐ Yes ☐ No Number of hours: _____

Return Completed Forms to Sutton Special Risk
33 Yonge St., Suite 400 Box 311
Toronto, ON M5E 1G4

D - FOLLOW-UP AND PROGNOSIS

Date of first consultation for this disability (YYYY/MM/DD): Next consultation:

Date of other consultations (YYYY/MM/DD): Follow-up frequency:

Referral to another physician: Yes No Name of Physician:

Specialty:

Approximate duration of disability: No. of days: No. of weeks: Unspecified or date of return to work (YYYY/MM/DD):

How long before the patient will be able to return to work: No. of days: No. of weeks:

Part-time Full-time Gradual return Specify:

E - ADDITIONAL INFORMATION

F - IDENTIFICATION OF THE PHYSICIAN

Family name, given name:

License number: Telephone: Fax:

General Practitioner Specialist Specify:

Signature Date (YYYY/MM/DD)