COMBINED INSURANCE®MD

Canadian Head Office: Claims Department
P.O. Box 3720 MIP • Markham, ON L3R 0X5 • Fax: 905-754-4362

COMBINED ASSURANCES®MD

PLEASE COMPLETE AND RETURN ON _____

Claim #

CLAIMANT'S SUPPLEMENTARY STATEMENT — *PLEASE PRINT*

Name	Telephone Number

Address

Please describe any complications of injury or illness since last report

List medical treatments received since last report

Doctor's name and address	Treatment dates (MM/DD/YYYY)	

Hospital where confined since last report	Date of hospitalization	
	From	To

Have you been totally disabled to this date?	Yes ☐ No ☐	MM/DD/YYYY
When did you resume part of your duties?		
When did you resume all of your duties?		
When do you expect to resume part of your duties?		
When do you expect to resume all of your duties?		

MY CLAIM IS ON THE FOLLOWING BASIS

		MM/DD/YYYY
Dates during which I was unable to perform **all** the duties pertaining to my usual occupation	First day of total disability	
	Last day of total disability	
Dates during which I was able to perform **part** of the duties pertaining to my usual occupation	First day of partial disability	
	Last day of partial disability	

EMPLOYER'S STATEMENT

	MM/DD/YYYY
First day of absence from work	
Return to work	

Partially disabled From: To:

Name of Employer

Signature	Title	Signed on MM/DD/YYYY

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE any hospital or physician who has attended me to disclose, when requested to do so by the Combined Insurance Company of America, any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ SIGNATURE OF CLAIMANT

_____ DATE (MM/DD/YYYY)

IMPORTANT: Please review your claim form. Is it complete? A form not fully completed may delay settlement of your claim. Please also retain a copy of both sides of your completed claim form.

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT — *PLEASE PRINT*

Please return completed form to your patient. The patient is responsible for securing this form and for charges made for its completion.

PATIENT NAME

1. DIAGNOSIS OF PRESENT CONDITION (SPECIFIC MEDICAL DIAGNOSIS)	A) PRIMARY B) SECONDARY (IF APPLICABLE)
2. INDICATE COMPLICATIONS OR NEW INDEPENDENT CONDITIONS, SUCH AS SURGERY, WHICH MAY PROLONG THE DISABILITY.	DESCRIBE
3. DATE OF LATEST ATTENDANCE	DATE (MM/DD/YYYY)
4. HAVE YOU BEEN ACTIVELY SUPERVISING PATIENT'S CARE?	YES ☐ IF YES, STATE FREQUENCY OF VISITS (ON RIGHT) WEEKLY ☐ MONTHLY ☐ NO ☐ IF NO, COMMENT IN REMARKS (#9) OTHER (SPECIFY)
5. IS PATIENT FOLLOWING RECOMMENDED TREATMENT PROGRAM?	YES ☐ IF YES, STATE DATE OF LATEST TREATMENT DATE (MM/DD/YYYY) _____ NO ☐ IF NO, COMMENT IN REMARKS (#9)
6. TO THE BEST OF YOUR KNOWLEDGE, IS THE PATIENT **TOTALLY** DISABLED (UNABLE TO WORK/PERFORM USUAL ACTIVITIES)?	YES ☐ IF YES, GIVE APPROXIMATE DATE WHEN PATIENT SHOULD BE ABLE TO RETURN TO WORK. DATE (MM/DD/YYYY) NO ☐ IF NO, ON WHAT DATE COULD THE PATIENT HAVE RETURNED TO WORK? DATE (MM/DD/YYYY) INDEFINITE ☐ IF INDEFINITE, GIVE THE ESTIMATED NUMBER OF ADDITIONAL WEEKS BEFORE SUCH RETURN _____
7. HOW LONG WAS OR WILL PATIENT BE **PARTIALLY** DISABLED (ABLE TO WORK PART-TIME AT OWN OCCUPATION)?	FROM (MM/DD/YYYY) TO (MM/DD/YYYY)
8. IS PATIENT A SUITABLE CANDIDATE FOR A REHABILITATION PROGRAM?	YES ☐ NO ☐
9. REMARKS. PLEASE PROVIDE COMMENTS AND FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL.	

PHYSICIAN'S NAME	TELEPHONE NUMBER
ADDRESS	POSTAL CODE
PHYSICIAN'S SIGNATURE	DATE (MM/DD/YYYY)