AGA BENEFIT SOLUTIONS

WEEKLY INDEMNITY CLAIM FORM
SELF-INSURED PLAN
DECLARATION OF ATTENDING PHYSICIAN

Physical illnesses

Note: for psychological illnesses, complete the form on the reverse

3500 de Maisonneuve Blvd West, Suite 2200, Westmount QC H3Z 3C1 E-mail: salaire@aga.ca Fax: 514 935-1147

Section to be filled out by patient

Last name : ______ First name : ______ Date of birth : ______

Contract No. : ______ Group/Division No. : ______ Certificate No. : ______

Complete in block letters and give to the patient

1. DIAGNOSIS

1.1 Principal : ______

1.2 Secondary : ______

1.3 Complications : ______

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

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the periods : ______

1.5 Is the disability related to : an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident ☐

date of the event : ______

a pregnancy No ☐ Yes ☐ a preventive withdrawal from work No ☐ Yes ☐ Scheduled date of delivery : ______

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

At the beginning of the disability	Currently

2. TREATMENT

2.1 Drugs – Name – Dosage : ______

______

2.2 Has the patient undergone or will undergo :

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

b) surgery No ☐ Yes ☐ Day surgery ☐ Type : ______

Surgical procedure : ______ → ↳ Date : ______

c) other treatments No ☐ Yes ☐ Specify : ______

d) hospitalization from ______ to ______ Name of hospital : ______

e) a short stay under observation No ☐ Yes ☐ # hours : ______

3. FOLLOW-UP AND PROGNOSIS

3.1 Date of first consultation for this disability: ______ Next consultation: ______

3.2 Dates of other consultations : ______ Follow-up frequency : ______

3.3 Date patient's condition first prevented them from working? ______

3.4 Referral to another physician : No ☐ Yes ☐ Name of physician : ______

Specialty : ______

3.5 Approximate duration of disability : # days ______ # weeks ______ Unspecified ☐ or date of return to work ______

3.6 How long before the patient will be able to return to work? # days ______ # weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify : ______

4. IDENTIFICATION OF THE PHYSICIAN

4.1 Last/first name (in block letters) : ______ Telephone : ( )

4.2 License No. : ______ Fax : ( )

General practitioner ☐ Specialist ☐ Specify : ______

4.3 Address : ______

Signature : ______ Date : ______

NOTE: THE PATIENT MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM

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1. DIAGNOSIS

1.1 Principal : ______

1.2 Secondary : ______

1.3 Current symptoms : ______

1.4 Degree of severity of all symptoms : Mild ☐ Moderate ☐ Severe ☐ With psychotic elements ☐

1.5 Does the interruption of work result from problems related to :

☐ marital/family life ☐ loss of employment or lay-off ☐ professional problems

☐ personal or interpersonal problems ☐ alcohol or drug abuse or gambling problems

☐ others problems Specify : ______

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

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the dates of previous episodes : ______

2. TREATMENT

2.1 Drugs – Name – Dosage : ______

______

2.2 Is the patient consulting : a psychiatrist No ☐ Yes ☐ a social worker No ☐ Yes ☐

a psychologist No ☐ Yes ☐ another health care provider No ☐ Yes ☐

If yes, name of the caregiver consulted : ______

2.3 Hospitalization : from ______ to ______ Name of hospital : ______

3. FOLLOW-UP AND PROGNOSIS

3.1 Date of first consultation for this disability: ______ Next consultation: ______

3.2 Dates of other consultations : ______ Follow-up frequency : ______

3.3 Date patient's condition first prevented them from working? ______

3.4 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician : ______

3.5 Approximate duration of disability : # days ______ # weeks ______ Unspecified ☐ or date of return to work ______

3.6 How long before the patient will be able to return to work? # days ______ # weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify : ______

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Signature : ______ Date: ______

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