GROUP LIFE BENEFITS
CERTIFICATE OF ATTENDING PHYSICIAN
DISMEMBERMENT OR LOSS

Patient's Name: _____

Patient's Address: _____

Group Policy Number: _____

1. (a) When did the accident happen? Month _____ Day _____ Year _____

   (b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

   (b) Date of most recent treatment. Month _____ Day _____ Year _____

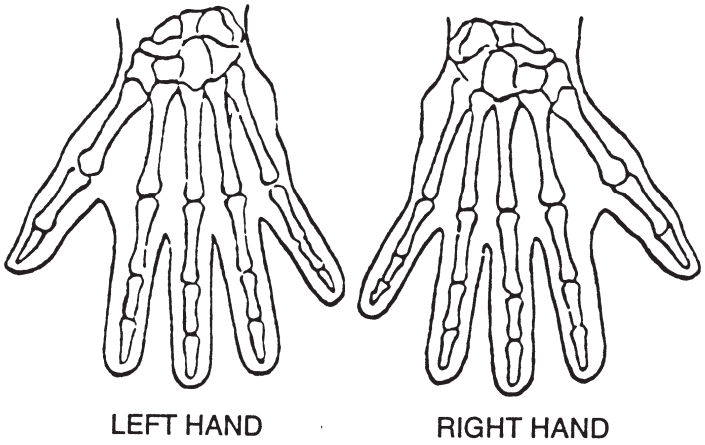
DISMEMBERMENT

3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

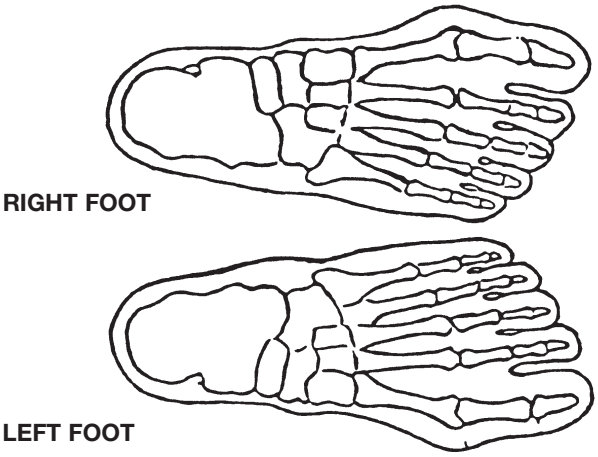
   ☐ Hand ☐ Foot ☐ Leg ☐ Arm ☐ Fingers ☐ Toes

   (b) Date of amputation. Month _____ Day _____ Year _____

   (c) Please include surgery report and hospital admittance and discharge summary.

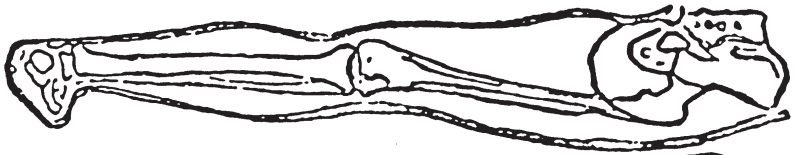


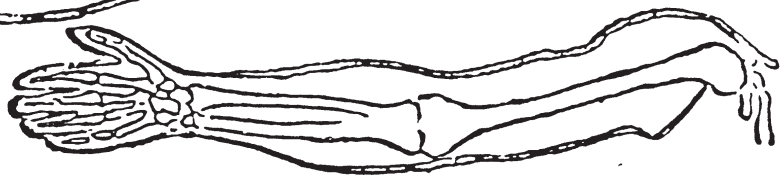
LEFT HAND RIGHT HAND



RIGHT FOOT

LEFT FOOT





INDICATE WHETHER RIGHT OR LEFT

4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which:

☐ Sight ☐ Hearing ☐ Speech

(b) Date on which loss occured. Month _____ Day _____ Year _____

(c) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

LOSS OF VISION

(a) If known to you, please advise the vision in each eye prior to the accident.

_____

(b) What is the best corrected vision in the affected eye(s), if any?

_____

(c) Please include visual acuity results and Opthalmologist report.

LOSS OF HEARING

(a) Is there any indication that hearing was abnormal prior to accident?

_____

(b) Level of hearing at date of loss.

_____

(c) Please include Audiologist report and hearing test.

LOSS OF SPEECH

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

_____

(b) Is insured's speech intelligible at the present time?

_____

(c) Please include Speech Therapy assessment.

LOSS OF USE

5. (a) If the accident caused loss of use of leg, arm, or hand, please advise which.

☐ Leg ☐ Arm ☐ Hand

(b) Is there any indication that the injured limb was unable to function normally prior to accident? ☐ Yes ☐ No

(c) Please indicate what functions, if any, the injured limb is able to perform.

_____

(d) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

(e) Please include: Hospital admittance and discharge summary, surgery report (if relevant), Range of Motion test results and Physiotherapist / Occupational Therapist reports, consultation and progress reports, Neurologic exam (paraplegia / quadriplegia).

6. (a) Was the injury described solely responsible for the loss? ☐ Yes ☐ No

(b) If not, give particulars of any contributing cause or causes.

_____

_____

Print Name _____ Specialty _____ Telephone Number: _____

Date _____ Signed _____ M.D.

Address _____

Street City Province Postal Code

Clear