NATIONAL BANK
INSURANCE

800 Saint-Jacques Street, office 43511, Montreal, Quebec H3C 1A3
Telephone: 514-871-7500 or 1-877-871-7500 - Fax: 1-866-394-6340

PSYCHOLOGICAL ILLNESSES
DISABILITY INSURANCE
Physician's statement

For physical illnesses, please complete the form specific to that purpose (F.29549-502).

IDENTIFICATION OF THE INSURED

First name _____ Last name _____ Date of birth (YYYY MM DD) _____ Gender: ☐ M ☐ F

PHYSICIAN'S STATEMENT

In order for us to properly assess the insured's claim, please answer all questions in as much detail as possible.

A. GENERAL INFORMATION

1. Are you the family physician? ☐ No ☐ Yes

   a) If so, how long have you been this person's physician (YYYY MM DD): _____

   b) If not, provide the name and contact information of the family physician:

   _____

   _____

2. To the best of your knowledge, does the patient currently use tobacco or marijuana, or a nicotine replacement product in any form whatsoever? ☐ No ☐ Yes ☐ Don't know

   If so:

   a) Indicate the type of substance and quantity consumed per day: _____

   b) How long has the patient been using this substance on a continuous basis (YYYY MM DD)? _____

   c) To the best of your knowledge, has the patient ever stopped using these substances for periods of time (from what date to what date)?

   _____

   _____

   If not:

   d) To the best of your knowledge, has the patient ever used tobacco or marijuana, or a nicotine replacement product in any form whatsoever? ☐ No ☐ Yes ☐ Don't know

   e) If so, specify the period(s) (from what date to what date) when he/she used these substances:

   _____

   _____

   f) Indicate the type of substance and quantity consumed per day: _____

   g) When did the patient stop using this substance (YYYY MM DD): _____

3. To the best of your knowledge, over the last three (3) years, has the patient used any unprescribed narcotics or drugs?
   ☐ No ☐ Yes ☐ Don't know

4. To the best of your knowledge, over the last three (3) years, has the patient received treatment or joined any organization because of his/her alcohol consumption, or has a health professional advised him/her to reduce his/her alcohol consumption?
   ☐ No ☐ Yes ☐ Don't know

B. DIAGNOSIS - Please use the DSM V nomenclature and codes to answer the following questions.

5. **AXIS I**

Primary diagnosis: _____

Secondary diagnosis: _____

6. **AXIS II**

Associated personality disorders? ☐ No ☐ Yes Specify: _____

Associated drug addiction, alcoholism or gambling problems? ☐ No ☐ Yes Specify: _____

7. **AXIS III - Associated illness**

Diagnosis: _____

Drugs prescribed: _____

8. **AXIS IV - Associated psychological stress factors**

☐ Personal or interpersonal problems ☐ Marital or family life ☐ Professional problems

☐ Loss of employment or layoff ☐ Alcohol or drug abuse, gambling problems

☐ Other, specify: _____

9. Specify the trigger:

_____

_____

10. What are the current symptoms you have observed in the patient?

_____

_____

11. How severe are the overall symptoms? ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements

12. When did the first symptoms appear? _____

13. Examination of current mental state (psychomotor skills, mood, affect, state of mind, cognitive skills):

_____

_____

_____

14. What are the patient's cognitive or mental limitations and their degree of severity?

a) Concentration: ☐ No limitation ☐ Mild ☐ Moderate ☐ Severe

b) Social interaction skills: ☐ No limitation ☐ Mild ☐ Moderate ☐ Severe

c) Understanding: ☐ No limitation ☐ Mild ☐ Moderate ☐ Severe

d) Reasoning: ☐ No limitation ☐ Mild ☐ Moderate ☐ Severe

e) Other: ☐ Specify: _____

f) Describe what day-to-day activities are affected by these limitations and how:

_____

_____

_____

15. Indicate the reason for the patient's initial consultation:

_____

_____

16. Are there any complications that could extend the period of disability? ☐ No ☐ Yes

a) If so, provide details:

_____

_____

17. Has the patient ever had the same or a similar condition? ☐ No ☐ Yes ☐ Don't know

a) If so, indicate when (YYYY MM DD) and describe the condition in detail and treatment received:

C. TREATMENT

18. Medication, dosage and date prescribed:

a) Gradual increase:

b) Potentiation:

c) Has there been any change in medication or do you anticipate such a change? ☐ No ☐ Yes

If yes, specify:

19. Is the patient consulting a: psychologist? ☐ No ☐ Yes Other? ☐ No ☐ Yes If yes, specify:

a) If so, indicate the name and contact information of the professional:

20. Has the patient been hospitalized for this condition? ☐ No ☐ Yes

Specify:

Date admitted (YYYY MM DD) Date discharged (YYYY MM DD)

Name of the hospital Address of the hospital (No., street, city, province, postal code)

21. Is the patient following the recommended treatment plan? ☐ No ☐ Yes

a) If not, provide details:

D. FOLLOW-UP AND PROGNOSIS

22. Date the patient stopped working because of his/her illness (YYYY MM DD):

23. Did the patient consult you on this date? ☐ No ☐ Yes

a) If not, provide the name and contact information of the physician the patient consulted on the date of his/her work stoppage:

b) When did he/she consult you for the first time (YYYY MM DD)?

24. Dates of consultations:

a) Frequency of consultations: Next consultation:

25. Will the patient be referred to a psychiatrist? ☐ No ☐ Yes

a) Name of physician:

b) Frequency of consultations:

26. If you anticipate that the absence from work will exceed the usual period for such a diagnosis, specify the factors that justify your prognosis:

27. Approximate duration of incapacity: or or

No. of weeks No. of months Scheduled date of return to work (YYYY MM DD)

E. MEDICAL HISTORY

28. Over the past five years, has the patient consulted or been treated by a health professional, had a medical exam or follow-up, or suffered from or been diagnosed with one of the following health issues: cardiac or blood vessel disorders, blood disorders including high cholesterol, high or low blood pressure, tumours or cancer, muscular dystrophy, multiple sclerosis, AIDS, HIV or any other immunological disorder, chest pains or angina, lung or respiratory problems, digestive problems, liver problems, intestinal problems, kidney problems, urinary tract problems, problems with reproductive organs, disorders of the nervous system, diabetes, fibromyalgia or chronic fatigue, back, neck or spinal column problems, problems with muscles, joints or bones, or psychological or psychiatric problems.
☐ No ☐ Yes ☐ Don't know

Illnesses	Date (YYYY MM DD)	Results/Treatment	Periods of hospitalization	When was the patient informed of the diagnosis?

Additional comments:

DOCUMENTS REQUIRED

Submit a copy of all medical examinations (laboratory results) and consultation reports (yours and those of specialists) and any other document related to the disability claim.

PHYSICIAN'S IDENTIFICATION

29. _____
First and last name

30. _____ ☐ General practitioner ☐ Specialist, specify: _____
Licence No.

31. _____
Address (No., street, city, province, postal code)

_____ _____
Telephone No. Fax No.

_____ **X** _____
Date (YYYY MM DD) Signature

NOTE: The insured must pay any fees charged to complete this form.