

Tuition Expenses - Attending Physician's Statement



Instructions to the student:

- Please complete, sign and date Section 1.
- Ask your physician to complete Section 2.

Please note that you are responsible for the cost of completing this form.

Instructions to the physician:

- Please complete, sign and date Section 2.
- Please enclose copies of chart notes, consult notes, investigations and test results that relate to your patient's claim for reimbursement of tuition and related expenses as a result of disability.

Securian Canada is committed to keeping your information confidential.

Please **PRINT** clearly.

1. Student information

This part of the form should be completed before the physician completes section 2.

Student last name	Middle initial	First name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Policy number(s)	Student ID number		
Date of birth (dd-mm-yyyy)	Height (cm)	Weight (kg)	

Patient's authorization

I authorize my doctor to collect, use and disclose my personal information to Canadian Premier Life Insurance Company ("Securian Canada"), its agents and service providers, its reinsurers and their service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature X	Date (dd-mm-yyyy)
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2. Physician's report

Canadian Premier Life Insurance Company ("Securian Canada") will use the information in this form to determine your patient's eligibility for reimbursement of tuition and related expenses as a result of disability.

We ask that you complete the Attending Physician's Statement as thoroughly as possible.

Please be assured that this information, including any medical records submitted in support of this tuition claim, will be treated confidentially.

Any information provided by you to Securian Canada regarding this tuition claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Diagnosis

Primary
Secondary

A. Mental/Nervous impairment (if applicable)

1. What symptoms is this patient displaying that indicate a mental impairment exists?

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2. Has there been a psychiatric referral?

Yes No

If yes, name of psychiatrist

3. What is the diagnos(es) using the DSM IV?

Axis I
Axis II
Axis III
Axis IV
Axis V
Remarks

B. Investigations

Describe the results of any examinations, laboratory tests, X-rays, ECGs, and all other investigations related to the patient's disability. Please include copies of test results and reports.

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2. Physician's report (continued)

C. History

1. What was the date of the patient's first appointment for the claimed disability?

Date (dd-mm-yyyy)

2. What was the date of the patient's latest appointment?

Date (dd-mm-yyyy)

3. How often are the patient's appointments?

Weekly Bi-weekly Monthly Other (please specify):

4. Did you recommend that patient stop attending all classes?

Yes No

As of what date?

Date (dd-mm-yyyy)

D. Treatment

1. Was the patient hospitalized?

Yes No

From (dd-mm-yyyy): To (dd-mm-yyyy):

2. Was surgery performed?

Yes No If yes, give details.

Date (mm-yyyy)	Type of surgery

3. If medication is being administered, please describe below:

Medication	Dosage	Date started (dd-mm-yyyy)	Date stopped (dd-mm-yyyy)	Response

4. What other treatments were given?

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5. What further treatment is being considered?

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2. Physician's report (continued)

E. Progress

6. Which of the following best describes the progress of the student's condition since the patient stopped attending all classes?

Recovered Improved Unchanged Retrogressed

F. Limitations

7. How is your patient limited from attending all classes? What prevents a return to college or university?

G. Prognosis

8. What is your patient's expected date of return to class?

Date (dd-mm-yyyy)

H. Remarks

I. Physician information

Last name	First name	Specialty	
Address (street number and name)			Apartment or suite
City		Province	Postal code
Telephone		Fax	

I. Physician's signature

Signature X	Date (dd-mm-yyyy)
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3. Mailing instructions

To ensure prompt submission, please fax this form, along with any other information in support of your claim that you would like to submit, to the number that appears below. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the address below. If you have any questions, please contact AAclaims@securiancanada.ca.

Securian Canada
Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

Fax number: 1-877-513-0708