

Impaired annuities medical form

(To be completed by the patient's family doctor or attending physician.)

Preliminary number

We (Sun Life Assurance Company of Canada, the company) are considering your patient's application for an impaired annuity and require the medical information below to assess the patient's eligibility.

Do not tell us about genetic testing or genetic testing results.

Patient's (applicant) first name		Middle initial	Last name	
Date of birth (dd-mm-yyyy)	Former last name (if name changed)			<input type="checkbox"/> Male <input type="checkbox"/> Female
Physician's first name		Middle initial	Last name	
Mailing address (number and street)		City	Province	Postal code
Telephone number	Fax number		Date completed (dd-mm-yyyy)	
Applicant's first name (if different from patient)		Middle initial	Last name	

The applicant (parent or legal guardian or representative, if the applicant does not have the capacity to sign) authorizes:

- any health care professional, physician, hospital, clinic or medically related facility, insurance company, investigative agencies or other organization, institution or person, including the members of the Sun Life Financial Group of companies, which includes this company that have records or knowledge of the patient, to give only that information necessary to the company for underwriting the applicant's application, and
- the company to release only the necessary personal information obtained during the underwriting process to the patient's personal physician, to any insurance company if an application has been made for an impaired annuity on the patient's life, and for any infections or communicable disease, to the Medical Office of Health where required by law.

Province signed	Date (dd-mm-yyyy)	Signature
	Signed on:	Applicant X
	Signed on:	Parent, legal guardian or representative X

A copy of this authorization is as valid as the original.

1 Last doctor's visit to physician filling out the form	
Reason for last visit	Date (dd-mm-yyyy)
Result of last visit	
Are you aware of other more recent visits to other physicians (specialists, locums, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', provide findings if known or provide name and address of the physician we should contact.	

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2 Current impairment(s) or reason(s) for disability

Impairment	Yes	Date of injury or impairment (dd-mm-yyyy)
Head injury	<input type="checkbox"/>	
Cerebral palsy	<input type="checkbox"/>	
Spinal cord injury – incomplete or complete paraplegia; incomplete or complete quadriplegia	<input type="checkbox"/>	
Seizure disorder	<input type="checkbox"/>	
Central nervous disorder	<input type="checkbox"/>	
Cancer/tumour	<input type="checkbox"/>	
Orthopedic conditions	<input type="checkbox"/>	
Pulmonary disease	<input type="checkbox"/>	
Psychiatric disorders	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	
Cardiac and circulatory conditions	<input type="checkbox"/>	
Cerebrovascular accident/intracranial bleed	<input type="checkbox"/>	
Gastrointestinal disorders	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	
Burns	<input type="checkbox"/>	
Major organ transplant	<input type="checkbox"/>	
Chronic pain syndrome	<input type="checkbox"/>	
Clinically evident genetic disorders	<input type="checkbox"/>	
Musculoskeletal injuries	<input type="checkbox"/>	
Other – please provide details:	<input type="checkbox"/>	

3 Current functionality: Activities of daily living

Indicate all activities your patient can perform independently.

Basic activities

Eating	<input type="checkbox"/>
Bathing	<input type="checkbox"/>
Dressing	<input type="checkbox"/>
Toileting	<input type="checkbox"/>
Transferring	<input type="checkbox"/>
Continence	<input type="checkbox"/>

Advanced activities

Manage finances	<input type="checkbox"/>
Cook	<input type="checkbox"/>
Shop	<input type="checkbox"/>
Home chores	<input type="checkbox"/>
Take medicines	<input type="checkbox"/>
Drive	<input type="checkbox"/>

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4 Applicable conditions

Check the conditions that are applicable.

Cognitive function	Degree of severity		
	Mild	Moderate	Severe
Decreased memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased executive functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Behavioural			
Personality changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			
Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss/tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired gait/coordination/balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired speech – aphasia, dysarthria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurogenic bladder/bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cranial nerve dysfunctions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemiparesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemiplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric			
Major depressive disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GAF score if known:			

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5 Living status

Check the conditions that are applicable.

Feeding	
G-tube fed	<input type="checkbox"/>
Fed by others	<input type="checkbox"/>
Feeds independently	<input type="checkbox"/>
Mobility	
Ambulates independently	<input type="checkbox"/>
Ambulates with a cane(s)	<input type="checkbox"/>
Ambulates with a wheeled walker	<input type="checkbox"/>
Ambulates with wheelchair (dependent)	<input type="checkbox"/>
Physical state	
Bed ridden	<input type="checkbox"/>
Semi-vegetative	<input type="checkbox"/>
Vegetative	<input type="checkbox"/>
Current residence status	
Resides independently	<input type="checkbox"/>
Resides independently but uses external home care services	<input type="checkbox"/>
Resides in a group home with some supervision for safety	<input type="checkbox"/>
Resides at home under the care of family member or personal attendant	<input type="checkbox"/>
Resides at home under the care of family member or personal attendant but gets 24/7 attendant care	<input type="checkbox"/>
Institutionalized with 24/7 attendant care	<input type="checkbox"/>

6 Employment status (check all that apply)

Employability takes into account overall cognitive and physical ability to be an employee, homemaker or student. This determination should take into account such considerations as the person's ability to:

- understand, remember and follow instructions;
- plan and carry out tasks at least at the level of an office clerk or in simple routine, repetitive industrial situation or can do school assignments;
- remain oriented, relevant and appropriate in work and other psychosocial situations; and
- get to and from work or shopping centres using private or public transportation effectively.

Tick all that apply.

Patient has been employed/in school continuously for the last 6 months	<input type="checkbox"/>
Patient is or can be employed in pre-injury occupation	<input type="checkbox"/>
Patient is or can be competitively employed in a different occupational role with retraining	<input type="checkbox"/>
Patient is or can be employed in a specially supervised work environment	<input type="checkbox"/>
Patient is unemployable	<input type="checkbox"/>

Province signed	Date (dd-mm-yyyy)	Signature of physician X
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