S D 6 - Loss of time benefit

Attending Physician's Supplementary Statement

(loss of time benefit)

Instructions

1. Please print.
2. Return completed form to your patient.
3. Any charge for completing this form is the patient's responsibility.

Patient's name

1. Diagnosis of present condition

2. a) Indicate complications or new independent conditions, such as surgery, which may prolong the absence from work.

b) Date of hospital admission (day, month, year)	Date of discharge (day, month, year)	3. Date of latest attendance (day, month, year)

4. a) Have you been actively supervising this patient's care?
   - ☐ Yes, state frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify)
   - ☐ No, please comment

b) Please describe the current nature of treatment including medications, therapies, etc.?

c) Is patient following recommended treatment program?
   - ☐ Yes ☐ No, please comment

5. a) To the best of your knowledge, is the patient unable to work at own occupation?
   - ☐ Yes, give approximate date when patient should be able to return to work (day, month, year)

   or

   estimated number of weeks before possible return

   - ☐ No, give date patient could have returned to work? (day, month, year)

6. Is patient a suitable candidate for rehabilitation program?
   - ☐ Yes ☐ No

7. Remarks - Please provide comments and further details which you feel would be helpful

Name of physician (please print)	Specialty	Telephone no. ( )

Address (number, street, city, province, postal code)

Signature	Date (day, month, year)

M5874-9/05

Supplementary Report of Attending Physician

Ford Group Health Programs Trust

To be Completed by Employer	Policy No.	Division No.	Certificate No.	Name of Employee
	55028			

Name of Employer

Ford Motor Company of Canada, Limited

Date	Signature of authorized official	Title

Note to Employee

This form should be returned to the disability plan administrator at the location where you work. Should you wish to submit this form directly to Great-West Life, please contact your employer for the appropriate mailing address.

Authorizations and Declarations

Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in the offices of an organization authorized by Great-West Life. This information about you may include contact information, cause of disability, treatment and medications and other medical or psychiatric information. We limit access to information in your files to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. The information is used to establish your entitlement, investigate or assess your claim, underwrite, administer or adjudicate claims under the group benefits plan, perform independent medical assessments, audit the group benefits plan, assist in rehabilitation or return to work planning, and administer the group benefits plan (the "Purposes").

I declare that I have read and I understand and agree with the contents of the box above entitled "Protecting Your Personal Information".

I certify that the statements in this form are true and complete and authorize:

- Great-West, third parties acting on its behalf, and reinsurers to collect, use and disclose my personal information as needed to fulfill the Purposes set out in the box entitled "Protecting Your Personal Information", above;
- For these Purposes, any health professional or rehabilitation provider, investigative agency, other insurance/reinsurance companies, administrators of government benefits, and any other organizations and individuals having relevant information to provide such information to Great-West and Great-West to provide relevant information to such parties;
- For these Purposes, Great-West to provide my personal information to my employer and my employer to provide my personal information to Great-West, provided that details regardng my diagnosis, treatment or medication will only be provided to physicians designated by my employer, except where necessary in the course of legal actions, appeals, arbitration hearings or the Informal Procedure for Review of Claims. Only those persons who need to access my personal information to carry out their duties in furtherance of the Purposes will have access to such personal information.

My consent is given freely and a copy of this authorization is as valid as the original.

Date _____ Year _____ Signature _____