THE Great-West Life ASSURANCE COMPANY

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 ________

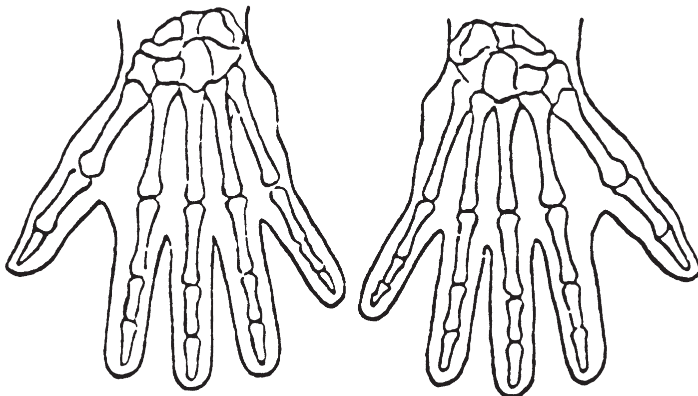
DISMEMBERMENT

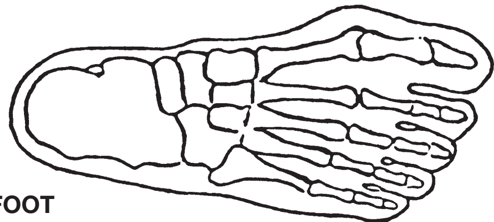
3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

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

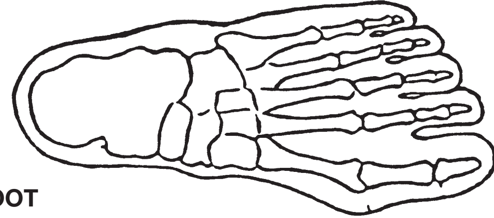
   (b) Date of amputation. Month ________ Day ________ Year ________

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





RIGHT FOOT



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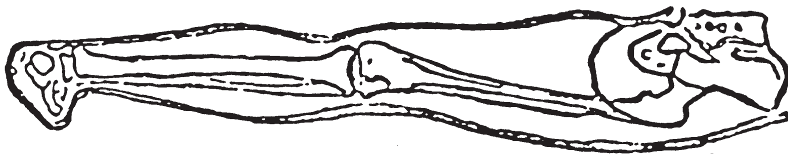

INDICATE WHETHER RIGHT OR LEFT

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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