

SUPPLEMENTAL REPORT FOR WAGE INDEMNITY BENEFITS

Group Number _____

Date: _____

In order to provide an update on your medical status, please complete the information below and have your attending physician complete the Attending Physician's Supplementary Statement. Return form promptly to:

D.A. Townley & Associates Ltd.
#101 - 4190 Lougheed Hwy
Burnaby, BC V5C 6A8

- If you will be disabled beyond _____, please have your attending physician complete the following Supplementary Statement.
- Further benefits will be held pending receipt and review of the following Supplementary Statement.
- Please have the following Attending Physician's Statement completed by your **Specialist**.

Member Last Name	First Name	Social Insurance Number
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Member Address _____

City	Province	Postal Code	Phone Number ()
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Have you recovered? Yes No If yes, on what date? _____

Have you returned to work? Yes No If yes, on what date? _____

I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley & Associates Ltd. any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

*Member/Employee Signature _____ Date: _____

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Please complete this claim form and return to your patient.

1. Patient's Name _____

2. Diagnosis _____

3. Presenting Symptoms: _____



4. Describe Surgery performed

Date: (Year/Month/Day)

Was this done under General Anaesthetic? Yes No

5. Complications or new independent condition which prolonged the disability:

6. Please outline any laboratory findings and forward copies of test results/consultation reports

7. (a) Are you treating patient? Yes No

(b) Dates of treatment for this period of disability:

8. Please outline treatment (include medication) and response to treatment

Is patient following recommended treatment program? Yes No If no, please explain:

9. Has patient been hospitalized? Yes No

Please indicate dates: From: _____ To: _____

10. Has patient been referred to a specialist? Yes No Appointment Date: _____

Name of specialist: _____

Please provide copies of any specialist reports

11. (a) Is patient totally disabled from his/her occupation? Yes No

(b) If No, give date patient could have returned to work _____

(c) If yes, approximately when will patient be able to return to work?

	<u>Own Occupation</u>	<u>Date/No. Weeks</u>	<u>Modified Duties</u>	<u>Date/No. Weeks</u>
Full Time	_____	_____	_____	_____
Part Time	_____	_____	_____	_____

12. What are the current disabling factors which prevent the patient from returning to work?

Additional comments:

Name of Attending Physician (please print)		Specialty (print)	Physician's Stamp here
Telephone Number	Signature	Date	
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Any charge for completing this form is patient's responsibility