

Insured's last name

Insured's first name

Date of birth:

Year	Month	Day
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Sex: ☐ F ☐ M

Contract No.

Client No.

**THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED FOR COMPLETING THIS FORM.****When disclosing medical and health information, the results of any genetic test should not be included.**

**1** Primary diagnosis: \_\_\_\_\_ Date of diagnosis: 

Year	Month	Day
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**2** Secondary diagnosis: \_\_\_\_\_ Date of diagnosis: 

Year	Month	Day
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**3** Date of last consultation: 

Year	Month	Day
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**4** Reason for consultation: \_\_\_\_\_

**5** Is the insured usually unable, **without the help of another person**, to perform the following activities of daily living?

**5.1 Feeding:** The ability to consume, with or without the use of adaptive utensils, food and drink prepared and served by others. ☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day
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Details: \_\_\_\_\_

**5.2 Bathing:** The ability to wash oneself in a bath or shower, including entering into and exiting from the bath or shower, or by a sponge bath, in such a way that an acceptable degree of hygiene is maintained. ☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day
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Details: \_\_\_\_\_

**5.3 Dressing:** The ability to put on or take off all necessary items of clothing and any medically necessary braces, surgical appliances or artificial limbs. Any item of clothing that can be made, purchased, or purchased and altered and that is reasonable for the insured's health, comfort and dignity in the environment in which he or she normally lives constitutes "necessary items of clothing."

☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day
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Details: \_\_\_\_\_

**5.4 Transferring:** The ability to move toward a bed, to get into and out of bed, and the ability to sit in a chair or a wheelchair and to get up from it with or without the assistance of auxiliary equipment. ☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day

Details: \_\_\_\_\_  
\_\_\_\_\_

**5.5 Toileting:** The ability to get to and from, on and off the toilet, and perform the associated personal hygiene.  
☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day

Details: \_\_\_\_\_  
\_\_\_\_\_

**5.6 Continence:** The ability to control bowel and bladder functions voluntarily, with or without surgical appliances or protection from incontinence, in such a way that an acceptable degree of hygiene is maintained. ☐ Yes ☐ No

Start of inability, if applicable: 

Year	Month	Day

Details: \_\_\_\_\_  
\_\_\_\_\_

**6** Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed at \_\_\_\_\_ on \_\_\_\_\_ this day of \_\_\_\_\_ 20 \_\_\_\_\_.

X

Attending physician's signature

Attending physician's full name (please print)

☐ General practitioner ☐ Specialist – Specify: \_\_\_\_\_ Licence No.: \_\_\_\_\_

Address (No., street, city, province)

Postal code

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Area code      Telephone

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