



ACE INA Insurance
 ACE INA Life Insurance
 The Exchange Tower
 130 King Street West, 12th Floor
 Toronto, Ontario M5X 1A6
 Telephone: 416-368-2911 1-877-772-7797

**CANADIAN ACTORS' EQUITY ASSOCIATION
 ACCIDENT & SICKNESS INSURANCE
 APPLICATION FOR INCOME
 REPLACEMENT BENEFITS
 ATTENDING PHYSICIAN'S STATEMENT**

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT, PLEASE RETURN COMPLETED FORM TO YOUR PATIENT

Patient's Name		Date of Birth:	
Is the condition due to injury or sickness arising out of the patient's employment?			
Diagnosis of the patient's condition: Primary:			
Secondary:			
If appropriate, additional conditions which might affect the duration of disability:			
To the best of my knowledge, the date the symptoms first appeared or accident happened on:			
Patient previously had same or similar condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, state when and describe:			
Dates of Hospital in-patient admission	From	To	
If surgery was performed, please describe:			
Date of surgery:			
If referred to you, give the name of referring physician:			
Date of first visit for present period of impairment:			
Date of latest attendance:			
Were you actively supervising this patient's care during this full period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please comment in additional remarks below.			
If yes, state frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Please specify)			
If the condition is due to pregnancy, what is (or was) the expected date of confinement?			
To the best of my knowledge, the patient has been unable to work	From	To	Inclusive
If still impaired and unable to work, give approximate date when the patient should be able to return to work:			
Or if indefinite, the estimated number of additional weeks before return			
How long was or will the patient be impaired and partially unable to work (Able to work part-time at own occupation);			
From	To		
How does present condition affect the patient's ability to work:			



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Physician's Name:		
Address		
City	Province	Postal Code
Phone # ()	Fax # ()	

Signature of Physician _____

Date _____