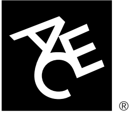

ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

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)? ☐ Yes ☐ 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? ☐ Yes ☐ No

If no, please comment in additional remarks below.

If yes, state frequency of visits: ☐ Weekly ☐ Monthly ☐ 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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CANADIAN ACTORS' EQUITY ASSOCIATION
ACCIDENT & SICKNESS INSURANCE
APPLICATION FOR INCOME
REPLACEMENT BENEFITS
ATTENDING PHYSICIAN'S STATEMENT

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

Signature of Physician ______________________________

Date ______________________________________