Overage Disabled Dependent

ASSOCIATION OF MANITOBA MUNICIPALITIES

Employee Name **Municipality Name**

Dependent Name **Date of Birth**

1. Diagnostic

1.1 Primary

1.2 Secondary

1.3 Current Symptoms

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

Mild: Suspected impairment of slight importance which does not affect functional ability.
Moderate: Impairment affects but does not preclude ability to function.
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

	Mild	Moderate	Moderately Severe	Severe
Degree of severity of all symptoms.				
Ability to relate to friends and family members.				
Ability to attend to personal care (bathing, cooking, etc.)				
Ability to carry out household chores.				
Understand, carry out, and remember instructions.				
Perform tasks involving minimal intellectual effort or repetitive tasks.				
Perform varied tasks.				
Make independent judgements.				
Perform intellectually complex tasks requiring higher levels of reasoning, math, and language.				

For the illnesses or associated symptoms diagnosed, the patient previously:

a) received medical treatments ☐ Yes ☐ No **b) consulted another physician** ☐ Yes ☐ No

c) taken drugs ☐ Yes ☐ No **d) been hospitalized** ☐ Yes ☐ No

e) undergone examinations ☐ Yes ☐ No

Specify the dates of previous episodes:

2. Treatment

2.1 Drugs - name - dosage - frequency:

2.2 Is the patient consulting:

a) a psychiatrist? ☐ Yes ☐ No

b) a psychologist? ☐ Yes ☐ No

c) a social worker? ☐ Yes ☐ No

d) another health care provider? ☐ Yes ☐ No

If yes, name of the caregiver:

2.3 Hospitalization: from to

Name of hospital:

3. Follow–up and Prognosis

3.1 Date of first consultation for this disability:

3.2 Follow-up frequency:

3.3 Approximate duration of disability: No. of weeks or months

3.4 Has the patient's condition within the past 12 months improved, worsened, or stayed the same? Please specify:

4. Information Regarding Dependent

4.1 Is the dependent currently living with his or her parent(s)?

4.2 Is the dependent able to support him or her self financially?

4.3 If the dependent is not living with the parent(s), please explain the dependent's living situation.

5. Identification of Physician

5.1 Family name, given name:

Telephone

5.2 License Number:

Fax:

☐ General Practitioner ☐ Specialist Specify:

Signature

Date:

6. Additional Comments

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

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Signature of Employee

Date Signed (yy/mm/dd)

Western FINANCIAL GROUP
Canada's Insurance Broker

Complete and send to:
Western Financial Group
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Fax: 204-943-5531