

Overage Disabled Dependent



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, has 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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- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

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Signature of Employee

Date Signed (yy/mm/dd)



Complete and send to:
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Western Financial Group (Network) Inc.
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