Canada Post Corporation Registered Pension Plan
Medical Assessment Questionnaire for a Disability Retirement Application (Plan 50666)

How to Complete this Form

Please complete this form in its entirety as soon as possible to expedite the processing of your application for disability retirement. If more space is required at any point on the form, please attach additional sheets of paper. The form must be signed by the plan member and the attending physician. The completed form and any additional documents must be mailed or faxed directly to:

THE CANADA LIFE ASSURANCE COMPANY
OTTAWA DISABILITY MANAGEMENT SERVICES OFFICE
302–1600 SCOTT STREET
OTTAWA ON K1Y 4N7

FAX: 1-844-569-3133
EMAIL: OTTAWA.DMSO@CANADALIFE.COM

Sections A — E To be Completed by the Plan Member

Section A — Plan Member Information

Employee No.

Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐

Surname | Given name | Initials

Home address Street and Number | City | Province | Postal Code | Telephone Number (Home)

Mailing address, if different from above.
Street and Number | City | Province | Postal Code | Telephone Number (Other)

Male ☐ Female ☐

Date of Birth (Y-M-D) Y A M D J

For Use by Canada Life Staff Member. File No.

Date Y A M D J

Section B — Work Information

Work address Street and Number | City | Province | Postal Code | Telephone Number (Work)

Job Title | Department

Description of Responsibilities | Last Date Worked Y A M D J

Have you done any other work for pay since your work absence from Canada Post commenced? Y ☐ N ☐ If yes, please describe below.

Start Date Y A M D J	End Date Y A M D J	Work Description

Section C — Other Activities Information

Have you returned to school or taken any training since your work absence from Canada Post commenced? Y ☐ N ☐
If yes, please describe below.

Start Date Y A M D J	End Date Y A M D J	Description - Name of School / Training Institution and Program

Have you done any volunteer activity since your work absence from Canada Post commenced? Y ☐ N ☐ If yes, please describe below.

Start Date Y A M D J	End Date Y A M D J	Description of volunteer activity

Section D — Summary of Education, Training and Work Experience

Please attach a copy of a current resumé, if available.
Otherwise, provide the following information.

Education — Include all forms of upgrading, in-service training, training on the job, special interest courses, etc.

Check all levels of completed education. High School ☐ College / University ☐ Other Training Institution ☐

Date of Completion (Y A / M / D J)	Name of School / Training Institution	Location / City and Province	Areas of Study / Level Obtained

Work Experience — Begin with most recent, include every job you have had in the last 15 years. If more space is required, use additional sheets of paper.

Start Date (Y A / M / D J)	End Date (Y A / M / D J)	Employer	Job Title

Section E — Medical Condition

Describe your current medical condition, including how it prevents you from working.

I hereby authorize the release of information held in my file by the physician named below to the Canada Life Assurance Company and its agents and service providers for the purposes of management and assessment of my application to determine my eligibility for disability retirement benefits under the Canada Post Registered Pension Plan. This medical information includes, but is not limited to copies of consultation reports, clinical notes, test results and hospital records supporting this claim. I understand that I am responsible for any costs related to the completion of this form.

Date (Y A / M / D J)

Plan Member Signature

Sections F–K To be Completed by the Attending Physician

Section F — Diagnosis

Primary diagnosis:

List any additional diagnoses or complications:

Section G — Physical Impairment

Does your patient have a physical impairment? Y ☐ N ☐ If yes, please complete this section.

Based on objective findings, what is patient's physical level of ability for:

	Max. Weight	Frequency		Duration	Frequency		Duration	Frequency
Lifting	lbs.		Sitting	hrs.		Standing	hrs.	
Carrying	lbs.		Walking	hrs.				

Please provide copies of consultation reports and test results (include copies of current X-rays, EKG's, or laboratory data and any other relevant data) and list all abnormal findings supporting the above restrictions.

Remarks:

Section H — Cognitive / Mental Impairment

Does your patient have a cognitive / mental impairment? Y ☐ N ☐ If yes, please complete this section.

Do you believe your patient is competent to endorse cheques and direct the use of proceeds thereof? Y ☐ N ☐

Indicate if patient has cognitive / mental restrictions in the following areas:

	None	Mild	Moderate	Severe
☐ Concentration				
☐ Analytical Reasoning				
☐ Learning New Material				
☐ Comprehension				
☐ Social Interaction				

What is the DSM IV diagnosis? (Axis 1)

What is the current GAF?

Please provide copies of consultation reports and your most recent mental status test results and list all abnormal findings supporting the above restrictions.

Section I — Cardiac (if applicable)

Functional Capacity

Class 1 ☐ No Limitation Class 2 ☐ Slight Limitation Class 3 ☐ Marked Limitation Class 4 ☐ Complete Limitation

Blood Pressure (Last 3 Visits)

Systolic		Date	Systolic		Date	Systolic		Date
Diastolic		Y A M D J	Diastolic		Y A M D J	Diastolic		Y A M D J

Section J — Visual Impairment (if applicable)

At last examination, what was your patient's vision?

OD with corrective lenses _____ without corrective lenses _____

OS with corrective lenses _____ without corrective lenses _____

Can vision be fully or partially restored? Y ☐ N ☐ If Yes, what are the treatment plans?

Section K — Treatment

Nature of Treatment - Including surgery, physiotherapy, psychotherapy, and medication prescribed and dosages.

☐ Surgery ☐ Physiotherapy ☐ Psychotherapy ☐ Medication _____

_____

_____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Date of last 3 consecutive visits

Date (Y A / M / D J) | Date (Y A / M / D J) | Date (Y A / M / D J)

Date of next scheduled visits

Date (Y A / M / D J) | Date (Y A / M / D J) | Date (Y A / M / D J)

Have you recommended that your patient's driver's licence be revoked? Y ☐ N ☐

Hospitalization

Has your patient been confined in a hospital? Y ☐ N ☐ If available, please include admission and discharge summaries.

Admission Date(s)

Date (Y A / M / D J) | Date (Y A / M / D J) | Date (Y A / M / D J)

Discharge Date(s)

Date (Y A / M / D J) | Date (Y A / M / D J) | Date (Y A / M / D J)

Name of other Treating Physician | Specialty | Address

_____ | _____ | _____

Name of other Treating Physician | Specialty | Address

_____ | _____ | _____

To your knowledge is your patient following the recommended treatment program? Y ☐ N ☐ Is there potential for future improvement? Y ☐ N ☐

If No, please advise if your patient's medical restrictions are expected to last for the remainder of his / her lifetime. _____

_____

_____

If Yes, when you do expect a significant change in the medical restrictions affecting your patient? _____

_____

_____

Final Remarks: _____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

Date (Y A / M / D J)

Signature of Attending Physician