BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

APPLICATION FOR DISABLED SELF PAY RATE

MEMBER STATEMENT

I hereby apply for the reduced self-pay rate. I certify that I remain disabled from my normal job.

I am not eligible for CPP Disability Pension because _____

_____

Signed _____ Date _____

Print Name _____ ID# _____

Address: _____
No. Street City Province Postal Code

ATTENDING PHYSICIAN'S AND SURGEON'S STATEMENT

1. History
   (a) When did present illness begin, or injury occur? _____
   (b) Date member was obliged to cease work. _____
   (c) Is there a previous history of this illness? _____

2. Present Condition
   a) Subjective symptoms _____
   (b) Objective Findings _____
   - give report of x-rays, EKG's or any other special tests _____
   _____
   c) Is patient (Ambulatory?
   (Bed Confined? _____
   (House Confined? _____
   (Hospital Confined? _____

3. Diagnosis
   _____
   _____
   _____

4. Treatment
   (a) Date of first visit _____
   (b) Date of last visit _____

(c) Frequency of visits _____

5. Progress (Recovered _____
(Improved _____
(Unimproved _____
(Retrogressed _____

Patient's name _____

6. Duration of Total Disability
(a) Is member still totally disabled from normal job? Yes___ No___
(b) If still disabled, when do you think he / she will be able to resume work?
(Approximate date _____
(Indefinite _____
(Never _____
(c) If no longer disabled, when was he / she able to resume any work?

_____
Month Day Year

7. Comments.

_____

_____

_____

Signature _____ M.D. Date _____

Physician's Name (print) _____

Address _____
No. Street City

_____
Province Postal Code