

# Overage Disabled Dependent

# TotalGUARD

|                |               |
|----------------|---------------|
| Employee Name  | Firm 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.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

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

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

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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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