**Submit online:**
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

**By mail:**
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

**By fax:**
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
Life • Health • Retirement

GROUP INSURANCE - DISABILITY CLAIMS

# DISABILITY OR WAIVER OF PREMIUM CLAIM
## EMPLOYER STATEMENT

## A - IDENTIFICATION
**We are unable to assess this claim unless all questions are answered completely.**

| EMPLOYEE Last name and first name | | Certificate or identification no. | Social insurance no.* |
|---|---|---|---|
| Chookomolin | David | | 495 886 590 |

| Address of employee - No., street, apt. | City | Province | Postal code |
|---|---|---|---|
| PO Box 182 | Attawapiskat | ON | P0L 1A0 |

Telephone no.: ( 705 ) 9 9 7 2 3 8 4 | E-mail address: dchookomolin@nanlegal.on.ca

| POLICYHOLDER OR EMPLOYER Name | Policy or group or contract no. | Division no. |
|---|---|---|
| CINUP | 641028 | |

| Address of policyholder or employer - No., street, suite | City | Province | Postal code |
|---|---|---|---|
| | | | |

Telephone no.: ( ) - | Fax no.: ( ) -

**COMPLETE IF SELF-ADMINISTERED:** **Effective date of coverage:** (YYYY MM DD) **Class no.:**

* Social insurance number is necessary only if the disability claims are taxable.

## B - GENERAL INFORMATION
**If the benefits are taxable, the basic tax deductions will be made. In all other cases, please provide the appropriate tax forms.**

**1** Current salary — Amount: $ 1,961.54
☐ Weekly ☐ Monthly ☑ Every two weeks

**2** Salary effective date (YYYY MM DD): 2022-04-16

**3** Job status: ☑ Full time ☐ Part time

**4** Indicate days in normal work week: ☐ SUN ☑ MON ☑ TUE ☑ WED ☑ THU ☑ FRI ☐ SAT
Hours worked per week: 35.00

**5** Type of schedule: ☐ Variable ☐ Rotating

**6** Premium paid by: ☑ Employer ☐ Employee ☐ Both

| 7 Date of employment (YYYY MM DD) | 8 Occupation | 9 Date last worked (YYYY MM DD) | No. of hours worked |
|---|---|---|---|
| 2018-01-08 | Youth Intervention Youth Justice Worker | 2022-07-29 | 7.00 |

**10** Is disability due to an accident? ☐ Yes ☑ No **If "Yes"**, date of accident: (YYYY MM DD)

**11** Did or will the employee receive any income during the disability period? ☑ Yes ☐ No **If "Yes"**, indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)
**Type:** Company Sick pay & Holiday pay **Amount:** $ 1,961.54 **Period:** Aug 1, 2022 to Aug 12, 2022

**12** If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (Québec only)? ☐ Yes ☑ No

**13** Has a claim been filed with a government agency? ☐ Yes ☑ No **If "Yes"**, indicate below:
☐ CNESST / WCB / WSIB / WHSCC ☐ CPP / QPP ☐ SAAQ (Québec only)
☐ Other, specify:
**Date Filed:** (YYYY MM DD) **Decision Rendered:** (YYYY MM DD) **Amount:** $

**14** Has the employee returned to work? ☐ Yes ☑ No **If "Yes"**, on what date? (YYYY MM DD)

**15** Is this person still in your employ? ☑ Yes ☐ No - Termination date: (YYYY MM DD) Reason:

**16** Was this person given a record of employment? ☐ Yes ☑ No

**17** Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work?
☑ No ☐ Yes - Please specify:

**18** Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☑ Yes ☐ No
If so, please indicate the percentage of employment income that is not taxable: 100.00 %

**PLEASE COMPLETE THE BACK OF THE FORM.**



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

## C - PHYSICAL WORK ENVIRONMENT

**Please attach a brief job description if available.**

**1** What are the main duties of the employee's job and how much time is allocated to each one weekly?

| Duties | | % | Duties | | % |
|---|---|---|---|---|---|
| Duties | Facilitation of Circles | 40 % | Duties | Writing of reports | 40 % |
| Duties | Attending Court | 10 % | Duties | Admin | 10 % |

**For questions 2 and 3, FREQUENCY is defined as follows:**

**OCCASIONALLY: 0-15 % of the times** **FREQUENTLY: 16-50 % of the time** **ALWAYS: 51 % + of the time**

**2** Work environment - Does the employee's job require work in any of the following conditions?

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☑ Outside | ☑ | ☐ | ☐ |
| ☑ In extremes of cold or heat | ☑ | ☐ | ☐ |

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☐ In a damp or humid environment | ☐ | ☐ | ☐ |
| ☐ Toxic fume | ☐ | ☐ | ☐ |

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☐ Above or below ground level | ☐ | ☐ | ☐ |
| ☐ Handling chemicals | ☐ | ☐ | ☐ |

Does the job involve other hazards? ☐ Yes ☐ No **If "Yes"**, please list:
Meet with clients face to face that may have covid or other communicable illnesses.

**3** Check the items below that relate to the employee's job, and complete the information requested.

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☐ Standing | ☑ | ☐ | ☐ |
| ☐ Walking | ☑ | ☐ | ☐ |
| ☐ Sitting | ☐ | ☑ | ☐ |
| ☐ Keeping one's balance | ☐ | ☐ | ☐ |

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☐ Bending over | ☐ | ☐ | ☐ |
| ☐ Kneeling | ☐ | ☐ | ☐ |
| ☐ Crouching | ☐ | ☐ | ☐ |
| ☐ Crawling | ☐ | ☐ | ☐ |

| FREQUENCY: | O | F | A |
|---|---|---|---|
| ☐ Extending/reaching above head | ☐ | ☐ | ☐ |
| ☐ Climbing | ☐ | ☐ | ☐ |
| ☐ Stairs (No. of steps _____) | ☐ | ☐ | ☐ |
| ☐ Ladders (Height _____) | ☐ | ☐ | ☐ |

| DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT: | FREQUENCY: O | F | A | WEIGHT: |
|---|---|---|---|---|
| ☐ Pushing | ☐ | ☐ | ☐ | ☐ Lb ☐ Kg |
| ☐ Pulling | ☐ | ☐ | ☐ | ☐ Lb ☐ Kg |
| ☐ Lifting/carrying | ☐ | ☐ | ☐ | ☐ Lb ☐ Kg |

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

| Type of equipment | Times per day |
|---|---|
| Type of equipment | Times per day |

**4** Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? ☑ Yes ☐ No

**If "Yes"**, please specify: Short deadlines- High volume referrals from court to be completed before next courts (Attawapiskat Every 3 Months)

**5** Does the employee's job require dexterity? ☐ Yes ☑ No

**If "Yes"**, please specify:

## D - ADDITIONAL INFORMATION

David was transferred to Kingston Hospital in critical condition. David was not well enought to fill out his STD forms for the first few weeks as he was in bad health. Therefore, once David was well enough, he worked with HR to access his company sick leave credits and holiday pay so as to ensure he had a source of income. David may be difficult to reach due to him attending his daily medical treatement. Please contact me if you cannot reach him.

## SIGNATURE OF THE AUTHORIZED PERSON

| Shwetz, Colette | HR Manager |
|---|---|
| Last name and first name of the authorized person (IN BLOCK LETTERS) | Position |
| cshwetz@nanlegal.on.ca | |
| E-mail address | |
| Colette Shwetz | Aug 29/22. |
| **Signature** | **Date** |

# Employee Statement

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G8
Send original forms and keep copies for your records.

By fax:
1-844-405-6571 (toll free)
416-926-0697
Keep original forms for your records.

Contact us: 1-800-263-1610 (toll free) or 416-926-2990

**Desjardins**
Insurance
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GROUP INSURANCE - DISABILITY CLAIMS

# DISABILITY OR WAIVER OF PREMIUM CLAIM
## EMPLOYEE STATEMENT

> **The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked «VOID».**

## A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

| Last name and first name of employee | Sex | Date of birth (YYYY MM DD) |
|---|---|---|
| Chotkowski, David | ☒ M ☐ F | 1973 04 22 |

| Address - No., street, apt. | City | Province | Postal code |
|---|---|---|---|
| P.O. Box 218 | Athwaye Lake | Ontario | P0L 1P0 |

| Policy or group or contract no. | Division no. | Certificate or identification no. | Social Insurance no.[1] |
|---|---|---|---|
| 641028 | | | |

Telephone no. (mandatory): ([redacted] [redacted] - 7686) ☐ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]: [redacted]

[1] Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
[2] Please provide this information only if you authorize Desjardins Insurance to email you.

## B - GENERAL INFORMATION

1. Training:

Level of education: Grade 12

Work experience: EMT, Nurses Aid, Security Guard, Part time Paramedic

Spoken language: ☒ English ☐ French Written language: ☐ English ☐ French

2. Is disability due to an accident? ☒ Yes ☐ No If "Yes", date of accident: YYYY MM DD: 2022 Time: ☒ AM ☐ PM Type of accident: ☒ Work-related ☐ Motor vehicle ☐ Other

Indicate details (where, how):

Headache DUE to a meeting in Southern Ontario

3. Did you receive prior treatment for the illness or injury causing the disability? ☐ Yes ☒ No
If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists:

First time

4. Name, address and telephone number of physicians and specialists who have treated you during the disability:

Now

**PLEASE COMPLETE THE BACK OF THE FORM.**



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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## B - GENERAL INFORMATION (CONTINUED)

5. If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

| Name of insurer | Policy no. | Certificate no. | Start date of benefits YYYY MM DD | End date of benefits YYYY MM DD | Benefit amount | Weekly/Monthly |
|---|---|---|---|---|---|---|
| | | | | | $ | ☐W ☐M |
| | | | | | $ | ☐W ☐M |

Comments:

## C - DIRECT DEPOSIT ENROLMENT

Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

| Name of financial institution | Institution no. | Transit/branch no. | Account no. |
|---|---|---|---|
| Bank of Montreal | 001 | 64142 | 3981967 |

Address - No., street, suite | City | Province | Postal code

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: [signature] Date: Aug 25/22

## D - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

## E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

**To be completed for each claim.**

I hereby certify that the above answers are full and true. I authorize Desjardins Insurance strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Signature of employee: [signature] Date: Aug 25/22

**VERY IMPORTANT**

**Please have the initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.**

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# Attending Physician Statement

**(Please take full package to your physician)**

completed

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GROUP INSURANCE - DISABILITY CLAIMS

## IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

| | |
|---|---|
| - General | Form no. 12018E01 |
| - Musculo-skeletal | Form no. 12019E01 |
| - Psychiatric/psychological | Form no. 12020E01 |
| - Cardiac | Form no. 12021E01 |
| - Cancer | Form no. 12022E01 |

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

**Desjardins Insurance**
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# INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

- A PLEASE PRINT.
- B PART 1 to be completed by patient.
- C PART 2 to be completed by physician.
- D Any charge for completion of this form is the patient's responsibility.

## PART 1 - Identification of patient

| Last name and first name (PLEASE PRINT) | Policy or group or contract no. | Certificate or identification no. | Date of birth |
|---|---|---|---|
| CHOOKOMOOLIN, DAVID | 841028 | | 1973 04 22 |

## PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

**1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.**

1.1 Primary: CARDIAC ARREST.

1.2 Secondary: KIDNEY FAILURE, COVID,

1.3 Subjective symptoms (including severity, frequency, duration): chest pain (CPR), shortness of breath

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):

1.5 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☒ Severe ☐ With psychotic elements

**2. History**

2.1 Date symptoms first appeared or accident happened: 2022 07 26

2.2 Date patient's condition first prevented them from working: 2022 07 26

2.3 Has this patient ever had same or similar condition? ☐ Yes ☒ No ☐ Unknown
If yes, please specify diagnosis and dates of treatment: n/a.

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☒ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☒ No ☐ Unknown

2.6 If patient is pregnant, give E.D.C.: n/a.

2.7 Names and specialties of other treating physicians: DR AMAR THAKRAR CPSO 85965.
DR. JOSEPH ABUNASSAR

2.8 Current height: 191 cm Current weight: 140 kg Weight loss/gain to date: -10 kg

**3. Treatment dates**

3.1 Date of first visit for current condition: 2022 07 27

3.2 Date of latest visit: in pt. current

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☒ Other (specify): DAILY.

3.4 Date of in-patient admission: 2022.07.27.

3.5 Date of discharge: pending.

3.6 Date of out-patient treatment:

3.7 Name of hospital: KINGSTON HEALTH SCIENCES.

**4. Nature of treatment**

4.1 Medications (dose, frequency, date prescribed): (see list)

4.2 Surgeries (including dates): (see attached)

4.3 Other (including frequency):

4.4 Is patient following recommended treatment program? ☒ Yes ☐ No (please elaborate):



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## 5. Progress

5.1 Has patient: ☐ Recovered ☒ Improved ☐ Not improved ☐ Retrogressed
5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☒ Hospital confined

## 6. Restrictions and limitations

| | | | HOURS AT ONE TIME | | | | | TOTAL HOURS DURING THE DAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | < 1 | < 1-2 | < 2-4 | 4-6 | 6-8 | < 1 | < 1-2 | < 2-4 | 4-6 | 6-8 |
| 6.1 | Stand | ☐ No restriction | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.2 | Walk | ☐ No restriction | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.3 | Walk on uneven surfaces | ☐ Yes ☒ No | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.4 | Sit | ☐ No restriction | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.5 | Drive | ☐ No restriction n/a | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.6 | This patient can lift/carry a maximum of: | kgs | 0 | 5 | 9 | 14 | 18 | 23 | 27 | 32 | 36 | 41+ |
| | | lbs | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90+ |
| 6.7 | ☐ No restriction | ☐ Repetitively: how much? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ Occasionally: how much? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
Drive: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulder):

## 7. Psychiatric illness (if applicable)

7.1 History: n/a.
7.2 Precipitating chronological events:
7.3 Work issue related to this illness:
7.4 Pre-morbid personality:
7.5 Changes in ADL habits:
7.6 Familial risk factors:
7.7 Progress with treatment plan:
7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☐ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility:
7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when:

## 8. Return to work plans

8.1 Prognosis for improvement or recovery: unknown
8.2 Expected date patient will return to their own occupation: unknown.
8.3 If unknown, please indicate the next follow up date: daily in hosp. bed
8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work:
8.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No
8.6 Please elaborate on time frames and patient's response:

## 9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☒ Yes ☐ No
If yes, please specify: CARDIOPULMONARY REHAB
9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☒ No If yes, please specify: - MAYBE IN WEEKS → MONTHS.

## 10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

n/a

## 11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): THAKKAR, AMAR
11.2 Specialty: CARDIOLOGY | License no.: 85955.
11.3 Address - No., street, suite: 166 BROCK ST City: KINGSTON Province: ON Postal code:
11.4 Telephone no.: (613) 544 3400 ext 2260 Fax no.: (613) 544 7250
Signature of physician: Date: 2022/8/25.



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South Eastern Ontario Health Science Centre
OPERATIVE REPORT - KGH

Name: Chookomoolin,David CR: 054-8124
DOB: 1973 Apr 22 Sex: M

Service Date: 2022 Aug 18
Family Physician: Green,Gordon M. Date Typed: 2022 Aug 18
Referring Physician: Meyer,Christopher Typed by: BTD
Surgeon: Louw,Jacob Status: Unverified
Dictated by: Greenblatt,Matthew Date Dictated: 2022 Aug 18

Copies to: Green,Gordon

---

Copies To: Gordon M Green (Print)

SURGEON: Dr. Jacob Louw

PROCEDURE: Upper endoscopy

ASSISTANT: Dr. Matthew Greenblatt PGY-5 Gastroenterology

SEDATION: As per ICU.

PRE-PROCEDURE: This is a 49-year-old patient that was admitted for pulmonary embolus with cardiac arrest. During his stay in the CCU, he developed what was thought to be hemoptysis or hematemesis. A CT scan of the chest and evaluation by Respirology did not demonstrate any clear site of the hemoptysis. Initial CT scan of thorax demonstrated a dilated esophagus full of food material; however, repeat CT scan done 48 hours later showed clearance of this material and as such, we were able to proceed safely to upper endoscopy today. In the past 48 hours, the patient has not demonstrated any clear overt GI blood loss.

CONSENT: The patient provided informed consent prior to beginning the procedure. We discussed the risks, which include but are not limited to cardiorespiratory depression with sedation, aspiration, perforation, and bleeding. The patient had understanding of the risks and there were no contraindications today.

PROCEDURE: The patient was placed in the left lateral decubitus position, the oropharynx was sprayed with topical Xylocaine. A bite block was applied. Fujifilm adult gastroscope was inserted into the oropharynx and the esophagus was intubated atraumatically under direct visualization. The squamocolumnar junction was relatively high and as such we realized that the patient may have varices. The GE junction was at 41 cm and the squamocolumnar junction was at 26 cm. There was no circumferential columnar appearing mucosa, however, there were islands of columnar appearing mucosa throughout this 15 cm segment. We then proceeded into the stomach and appreciated the features of the stomach with a lack of rugal folds in the body and fundus. No active or residual blood was found in the stomach. We then passed into the duodenum and there was no bleeding. The distal duodenum was visualized and photographed. We then returned into the antrum and did not identify any ulcers. On retroflexion, no evidence of gastric varices or any other mucosal lesions. We then returned back into the GE junction and there was evidence of LA B esophagitis at this time. Considering that the indication for this endoscopy was an acute GI bleed, we decided not to proceed to biopsies of the stomach or esophagus. We removed the endoscope

******** REPRINT OF CHART COPY ********
Report printed by - Thakrar,Amar
Report requested by - _____



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# Direction and Authorization Form

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM David Chodkowski
Employee's (Claimant Name)

TO Desjardins Financial

RE RELEASE OF CONFIDENTIAL/PERSONAL INFORMATION TO JG Benefits Inc./CINUP (hereinafter "Policyholder")

INDIVIDUAL POLICY NUMBER : Select Policy Number

I hereby direct and authorize the company to discuss with the Policyholder (JG Benefits Inc./CINUP) any and all information or documentation concerning my claim and its evaluation by the company, including but not limited to, any medical, financial, vocational, rehabilitation, or any other confidential/personal information or documentation concerning my claim. I also authorize the Company (Desjardins Financial) to send to the policyholder, copies of correspondence the Company receives from me concerning my claim as well as any medical information received from external sources.

**Duration and Revocation**

I understand that

- It is not a requirement of the Policy/Policies that I authorize the company to disclose information to the Policyholder
- This authorization will remain valid for as long as I am claiming benefits or service from the Company: and,
- I am free to revoke this authorization at any time by sending written notice to the Company of such revocation.

I have read and understand the above. I am signing this voluntarily, and not under compulsion by anyone.

Signature of Claimant

Aug 25/

Date