F54-381A(16-06)

Disability Claim Form

Initial Request

iA Financial Group

INVESTED IN YOU.

ia.ca

iA Financial Group

DISABILITY CLAIM FORM
Initial Request

GROUP INSURANCE

According to your region, please submit the completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

INSTRUCTIONS

In order to properly complete the form, each party should follow the instructions below.

POLICYHOLDER (Employer or plan administrator)

1. Please complete the "Policyholder's Statement" and ensure that you answer all questions to avoid file review delays.
2. For long-term disability or waiver of premium without short-term disability coverage requests, Industrial Alliance Insurance and Financial Services Inc. must receive the duly completed form signed by all parties **6 to 8 weeks before the waiting period expires.**

MEMBER

1. Please complete the "Member's Statement" and ensure that you answer all questions to avoid file review delays. Don't forget to sign the "Member Confirmation/Authorization" in Part 7.
2. Please ensure that your attending physician completes the medical declaration that applies to your condition (physical and/or psychological). You must also complete the "Member Identification" section AND you must sign the "Member Authorization" at the top of the physician's declaration.
3. Please enclose a photocopy of the benefit statement from any government plan under which you are receiving benefits (Régie des rentes du Québec, Canada Pension Plan, workers' compensation, auto insurance, victim of criminal act compensation, etc.)
4. Attach a copy of all correspondence received from any government plan mentioned in number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of the file.

Note:

a) It is your responsibility to pay any fees that may be incurred to have this form completed by your attending physician.

b) During the course of a disability, it is very important to read the comments provided on your benefit cheque stubs. These comments are to inform you of any decisions that have been made as well as to request any additional information that may be required in case of an extended disability.

c) Please return the entire document to the applicable address above. Do not detach any pages.

ATTENDING PHYSICIAN

1. Please complete the medical declaration that applies to the condition of your patient (physical and/or psychological) ensuring that you answer all questions to avoid file review delays.
2. Please attach any other documentation pertinent to the analysis of the request (test results of various examinations carried out and specialist consultation reports) to the form.

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Toronto, Ontario M5G 1Y7

Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

POLICYHOLDER'S STATEMENT

TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.

Policyholder's name _____

Address _____ Postal code |_|_|_|_|_|_|

Telephone |_|_|_| |_|_|_|_|_|_|_| Email _____

Authorized person's name _____

PART 1 – MEMBER INFORMATION

1. Member's name _____

2. Policy no. |_|_|_|_|_| Division no. |_|_|_| Class no. |_|_|_| Certificate no. |_|_|_|_|_|_|_|_|_|

3. Occupation (Please attach a copy of the job description and complete the table below) _____

Type of position: Regular position ☐ Temporary assignment ☐ (Indicate the start date) Y |_|_|_|_| M |_|_| D |_|_|

4. In the appropriate column, specify the amount of time the member regularly spends on the following activities:

A) During the same period of the day, without pause or interruption (approximately)

B) Total time during the day (approximately)

Analysis of physical requirements		A	B
– Sitting			
– Standing			
– Driving			
– Stooping			
– Climbing			
– Lifting	0 - 10 lbs. ☐		
	10 - 20 lbs. ☐		
	20 - 50 lbs. ☐		
	50 lbs. or over ☐		
Using a lift apparatus?	Yes ☐ No ☐		
– Pushing or pulling	0 - 10 lbs. ☐		
	10 - 20 lbs. ☐		
	20 - 50 lbs. ☐		
	50 lbs. or over ☐		

5. Was the coverage in effect on the first day of the disability period? Yes ☐ No ☐

If not, please explain. _____

If so, what is the effective date of the member's disability insurance coverage? Y |_|_|_|_| M |_|_| D |_|_|

PART 1 – MEMBER INFORMATION (Continued)

6. Date hired (Y M D) Certificate effective date (Y M D)

Last day at work (Y M D)

7. Date of return to work (if applicable) (Y M D) Full-time ☐ Part-time ☐ Regular job ☐

8. Primary reason for disability: Illness ☐ Accident outside of work ☐ Accident at work ☐
Motor vehicle accident ❑ Occupational illness ☐

9. On the date the disability commenced, was the employee: On vacation ☐ Laid off ☐ On paid leave ☐ On unpaid leave ☐
On disciplinary suspension without pay ☐
On disciplinary suspension with pay ☐ Other ☐ _____

PART 2 – MEMBER'S WORK SCHEDULE AND EARNINGS INFORMATION

1. Indicate the hours of work in a normal week: _____ For an irregular schedule, indicate the daily schedule.

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____

2. Gross salary prior to date of disability: $ _____ Annual ☐ Monthly ☐ Biweekly ☐ Weekly ☐ Other ☐
for _____ number of hours Annual ☐ Monthly ☐ Biweekly ☐ Weekly ☐ Other ☐

3. Tax credits: Federal (TD1)_____ Provincial (TPD1) _____

4. Has or will the member receive other amounts apart from the disability insurance benefits during the disability period? Yes ☐ No ☐
Specify: Vacation ☐ Maternity leave ☐ Employment Insurance (HRSDC) ☐ Sick leave ☐ Statutory holiday ☐
Other ☐ _____ Amount $_____

From _____ to _____

5. Has the member applied or will be applying for benefits from any of the organizations indicated below? Yes ☐ No ☐

If so, please specify:

Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization ☐
Société de l'assurance automobile du Québec (SAAQ) or other similar organization ☐
Human Resources and Social Development Canada (HRSDC) ☐
Régie des rentes du Québec (RRQ) ☐ Disability pension ☐ Retirement pension ☐
Canada Pension Plan (CPP) ☐ Disability pension ☐ Retirement pension ☐
Other (specify) ☐_____

6. If the member is already receiving benefits from one of the sources above, please indicate the amount: $_____
Attach a copy of the letter of acceptance and the most recent cheque stub, if applicable.

7. If necessary, are you able to provide a job: with a gradual return to work? ☐ with light duties? ☐

8. Please indicate any other comments relevant to this claim.

_____

_____

I certify the accuracy of the information above.

Authorized signature _____ Date (Y M D)

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Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

MEMBER'S STATEMENT

TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

PART 1 – IDENTIFICATION

Last name _____ First name _____ Sex Female ☐ Male ☐

Policy no. |_|_|_|_|_| Social Insurance Number |_|_|_|_|_|_|_|_|_| Certificate no. |_|_|_|_|_|_|_|_|_|_|

Date of birth (Y M D) |_|_|_|_|_|_| Occupation _____ Language French ☐ English ☐

PART 2 – REASON FOR THE CLAIM

1. Accident. If the sick leave was the result of an accident, indicate:

- Place of the accident: Home ☐ Work ☐ Elsewhere ☐ (specify) _____
- Date of the accident (Y M D) |_|_|_|_|_|_| Circumstances _____
- If a car accident, specify whether you were: Driver ☐ Passenger ☐ If not a Quebec resident, please submit the police report.

2. Is the period of disability due to work-related problems? No ☐ Yes ☐ Specify _____

_____

PART 3 – OCCUPATION

Date hired (Y M D) |_|_|_|_|_|_| When did you become unable to work? Date (Y M D) |_|_|_|_|_|_|

1. Explain how your condition is preventing you from working.

_____

_____

_____

2. Describe the duties of your job that you can no longer perform.

_____

_____

_____

3. When you stopped working, were you working anywhere else (second job)? If yes, specify. _____

_____

_____

PART 4 – CURRENT SITUATION

1. Are you confined to your home? No ☐ Yes ☐
Confined to your bed? No ☐ Yes ☐
Hospitalized? No ☐ Yes ☐

2. Please describe all your symptoms including severity and frequency.

_____

_____

_____

3. Describe your current activities of daily living since going on sick leave.

_____

_____

_____

PART 5 – INCOME FROM OTHER SOURCES

Indicate if you have applied or will be applying for benefits from any of the following sources:

– Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization No ☐ Yes ☐ Date Y M D

– Société de l'assurance automobile du Québec (SAAQ) or other similar organization No ☐ Yes ☐ Date

– Human Resources and Social Development Canada (HRSDC) No ☐ Yes ☐ Date

– Régie des rentes du Québec (RRQ) Disability pension ☐ Retirement pension ☐ No ☐ Yes ☐ Date

– Canada Pension Plan (CPP) Disability pension ☐ Retirement pension ☐ No ☐ Yes ☐ Date

– Other (specify) _____ Date

If you have already applied for benefits, please provide a copy of all correspondence, including the decision, if applicable.

PART 6 – PHYSICIANS AND HISTORY

1. Name of your attending physician_____ Date of initial visit Y M D

Address _____

2. Have you been hospitalized for this medical condition? No ☐ Yes ☐ Date Y M D

Name of hospital _____

3. When did your symptoms start? _____

4. When did you first consult a physician for this medical condition?_____

5. Have you ever had a similar illness or injury before? No ☐ Yes ☐ Date Y M D

6. Would you be able to return to work gradually? No ☐ Yes ☐

7. Has your attending physician prescribed medication? No ☐ Yes ☐ If so, are you taking it regularly? No ☐ Yes ☐

8. List all the physicians who have treated you in the last two years.

Illness	Consultation or treatment date	Treatment prescribed, medication, other	Name and address of physician

PART 7 – MEMBER CONFIRMATION/AUTHORIZATION

I CONFIRM that the statements provided in the Member's Statement and all statements provided in any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge. I AGREE that all such statements form the basis for any benefits approved as a result of this claim.

I HEREBY AUTHORIZE:

(i) Any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (the Company), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim;

(ii) The Company to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and

(iii) The Company and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

A photocopy of this Confirmation/Authorization shall be as valid as the original.

This Confirmation/Authorization is valid only for this disability claim.

Member's signature_____ Date Y M D

Address _____

Postal code Home Work

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Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

MEMBER IDENTIFICATION (The member must complete this section)

Last name _____ First name _____

Policy no. _____ Social Insurance Number _____ Certificate no. _____

Date of birth Y M D _____

MEMBER AUTHORIZATION

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (the Company), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim.

A photocopy of this Authorization shall be as valid as the original.

This Authorization is valid only for this disability claim.

Member's signature _____ Date Y M D _____

Address _____

Postal code _____ Home _____ _____ Work _____ _____

ATTENDING PHYSICIAN'S STATEMENT – PSYCHOLOGICAL ILLNESS

Please print and give to the patient

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST

PART 1 – DIAGNOSIS

1. Primary diagnosis: (Axis I) _____

2. Secondary: (Axis II, III) Personality disorders and other medical conditions.

_____

_____

3. Among the current symptoms, please identify the ones that you observed during office visits.

_____

_____

4. Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe with psychotic elements ☐

5. Does the interruption of work result from problems related to:
Marital/family life ☐ Loss of employment or layoff ☐ Alcohol or drug abuse and/or gambling problems ☐
Personal or interpersonal problems ☐ Professional problems ☐
Other problems ☐ (specify) _____

6. Current Global Assessment of Functioning (GAF) score _____

7. Highest level of functioning (GAF score) in the last year (0-100) _____

8. Current mental status examination (psychomotor activity, mood, affect, thinking, cognitive abilities)

_____

_____

9. For the illnesses or associated symptoms diagnosed, has the patient previously:
Received medical treatments ☐ Consulted another physician ☐ Taken medication ☐ Been hospitalized ☐
Undergone examinations ☐ Specify the dates of previous episodes: _____

PART 2 – LIMITATIONS AND RESTRICTIONS

1. What are your patient's current limitations **(what he/she cannot do)**? _____

_____

2. What restrictions are currently placed on your patient **(what he/she should not do)**? _____

_____

3. Is the patient able to attend his/her affairs, particularly the endorsement of cheques? No ☐ Yes ☐

PART 3 – TREATMENT

1. Medication (name and dosage): _____

_____

2. Medication strategies:

Progressive increase _____

Potentialization _____

Combinations _____

Medication changes _____

3. Is the patient consulting: Psychiatrist? No ☐ Yes ☐ Social worker? No ☐ Yes ☐

Psychologist? No ☐ Yes ☐ Other healthcare provider? No ☐ Yes ☐

If yes, name of the healthcare provider: _____

4. Hospitalization: From Y M D to Y M D

Name of hospital _____

PART 4 – FOLLOW-UP AND PROGNOSIS

1. Date of first consultation for this disability: Y M D Starting date of disability: Y M D

Next consultation: Y M D

2. Dates of other consultations: Y M D Follow-up frequency: _____

3. Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician: _____

4. Approximate duration of disability: Number of weeks _____ or number of months _____ or undetermined ☐

or date of return to work: Y M D

5. When will your patient be fit to return to work? Y M D

Part-time ☐ Full-time ☐ If gradual return ☐ please explain why: _____

_____

6. Recommended return to work plan Program start date Y M D

Week 1 _____ days a week Date Y M D Week 3 _____ days a week Date Y M D

Week 2 _____ days a week Date Y M D Week 4 _____ days a week Date Y M D

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. Last and first name _____ Telephone

2. Address _____ Fax

3. General practitioner ☐ Specialist ☐ Other ☐ Specify: _____

Signature _____ Date Y M D

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.

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MEMBER IDENTIFICATION (The member must complete this section)

Last name _____ First name _____

Policy no. _____ Social Insurance Number _____ Certificate no. _____

Date of birth Y M D _____

MEMBER AUTHORIZATION

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (the Company), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim.

A photocopy of this Authorization shall be as valid as the original.

This Authorization is valid only for this disability claim.

Member's signature _____ Date Y M D _____

Address _____

Postal code _____ Home _____ _____ Work _____ _____

ATTENDING PHYSICIAN'S STATEMENT – PHYSICAL ILLNESS

Please print and give to the patient

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST

PART 1 – DIAGNOSIS

1. Primary: _____

2. Secondary: _____

3. Complications: _____

4. For the illnesses or associated symptoms diagnosed, has the patient previously:
received medical treatments ☐ consulted another physician ☐ taken medication ☐ been hospitalized ☐
undergone examinations ☐ Specify the periods: _____

5. a) Is the disability related to the specific risks of this patient's job?
No ☐ Yes ☐ If so, explain: _____

b) Is the disability related to: Accident ☐ Illness ☐ Work accident ☐ Occupational illness ☐
Motor vehicle accident ☐ Date of the event Y M D _____

c) Pregnancy No ☐ Yes ☐ Expected date of delivery Y M D _____
Preventive leave No ☐ Yes ☐ Start date Y M D _____

6. Describe the functional limitations that prevent the patient from carrying out professional duties or usual daily activities.

At the beginning of disability Date:	Currently

Height: _____ m Weight: _____ kg Right-handed ☐ Left-handed ☐

PART 2 – LIMITATIONS AND RESTRICTIONS

1. What are your patient's current limitations **(what he/she cannot do)**? _____

_____

2. What restrictions are currently placed on your patient **(what he/she should not do)**? _____

_____

3. Cardiac status (if related to the disability):

a) Functional capacity (American Heart Association) Class I (no limitation) ☐ Class II (slight limitation) ☐
Class III (marked limitation) ☐ Class IV (severe limitation) ☐

b) Blood pressure (last visit) Systolic_____ Diastolic _____

c) Is the patient able to attend his/her affairs, particularly the endorsement of cheques? No ☐ Yes ☐

PART 3 – TREATMENT

1. Medication (name and dosage): _____

_____

2. Has the patient undergone or will undergo:

a) Examinations or tests No ☐ Yes ☐ Specify:_____

b) Surgery No ☐ Yes ☐ Day surgery ☐ Type:_____ Date: Y M D

Surgical procedure: _____

c) Other treatments? No ☐ Yes ☐ Specify: _____

d) Hospitalization From Y M D to Y M D

Name of hospital: _____

e) A short stay under observation (number of hours): _____

PART 4 – FOLLOW-UP AND PROGNOSIS

1. Date of first consultation for this disability: Y M D Starting date of disability: Y M D

Next consultation: Y M D

2. Dates of other consultations: Y M D Follow-up frequency: _____

3. Referral to another physician: No ☐ Yes ☐ Name of physician:_____

Speciality:_____

4. Approximate duration of disability: Number of weeks _____ or number of months _____ or undetermined ☐

or date of return to work: Y M D

5. When will your patient be fit to return to work? Y M D

Part-time ☐ Full-time ☐ If gradual return ☐ please explain why: _____

_____

6. Recommended return to work plan Program start date Y M D

Week 1 _____ days a week Date Y M D Week 3 _____ days a week Date Y M D

Week 2 _____ days a week Date Y M D Week 4 _____ days a week Date Y M D

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. Last and first name _____ Telephone

2. Address _____ Fax

3. General practitioner ☐ Specialist ☐ Other ☐ Specify: _____

Signature _____ Date Y M D

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.