

**GROUP  
INSURANCE**



F54-382A(17-09)

# **Disability Claim Form**

Extension of Disability



**INVESTED IN YOU.**

iA Financial Group is a business name and trademark of  
**Industrial Alliance Insurance and Financial Services Inc.**

**ia.ca**

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

**Quebec**  
**Disability Claims**  
PO Box 790, Station B  
Montreal, Quebec H3B 3K6

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

## INSTRUCTIONS

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

### 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 4.
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 sign the "Member Authorization" at the top of the physician's declaration.
3. Please enclose a photocopy of the benefit statement from the 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 the applicable government plan mentioned in Number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of your file.

Note:

- a) It is your responsibility to pay any fees that are applicable 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 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) and ensure that you answer all questions to avoid file review delays.
2. Please attach any other documentation pertinent to the analysis of the request (such as the results of various examinations carried out and specialist reports) to the form.

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

**Quebec Disability Claims**  
 PO Box 790, Station B  
 Montreal, Quebec H3B 3K6

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

**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: \_\_\_\_\_ Occupation: \_\_\_\_\_ Language: French  English

**PART 2 – CURRENT SITUATION**

1. Since the date of the initial request: Are you confined to your home? No  Yes   
 Confined to your bed? No  Yes   
 Hospitalized? No  Yes

2. Please describe all your symptoms including their severity and frequency: \_\_\_\_\_

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

4. When do you expect to return to work full or part time? \_\_\_\_\_

**PART 3 – INCOME FROM OTHER SOURCES**

Have you applied or will you 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: \_\_\_\_\_
- 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: \_\_\_\_\_
- RCanada 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 4 – 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: \_\_\_\_\_

Address: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home tel.: \_\_\_\_\_ Work tel.: \_\_\_\_\_

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

**Quebec**  
**Disability Claims**  
 PO Box 790, Station B  
 Montreal, Quebec H3B 3K6

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

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

**MEMBER IDENTIFICATION (The member must complete this section)**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Sex: Female  Male

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 tel.: \_\_\_\_\_ Work tel.: \_\_\_\_\_

**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. DSM-IV DIAGNOSIS**

1.1 AXIS I) Psychiatric disorder: \_\_\_\_\_

1.2 Please describe the signs and symptoms, indicating the frequency and the degree of severity of each one:

M = Mild Md = Moderate S = Severe

Signs	M	Md	S	Symptoms	M	Md	S
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AXIS II) Are there any associated personality disorders? No  Yes  Specify: \_\_\_\_\_

Are there any associated drug addiction, alcoholism or gambling problems? No  Yes

If so, please specify: \_\_\_\_\_

AXIS III) General medical condition: – Diagnosis: \_\_\_\_\_

– Medication prescribed: \_\_\_\_\_

AXIS IV) Associated psychosocial problems (in the past 12 months):

- Personal or interpersonal problems     Alcohol or drug abuse and/or gambling problems  
 Marital or family problems  
 Job loss or layoff                                       Work-related problems  
 Other, please specify: \_\_\_\_\_

AXIS V) Global assessment of functioning – Highest level in the past year: GAF score (0-100) \_\_\_\_\_

– Highest level in the past year: GAF score (0-100) \_\_\_\_\_

**PART 2 – TREATMENT AND VISITS**

2.1. Medication: \_\_\_\_\_

Date started	Name	Dosage	Frequency

2.2. Treatment strategies with medication:

- Increased on \_\_\_\_\_ Name and dosage \_\_\_\_\_
- Maximized on \_\_\_\_\_ Name and dosage \_\_\_\_\_
- Combined on \_\_\_\_\_ Name and dosage \_\_\_\_\_

2.3. Please indicate whether your patient is consulting: Since when?

A psychiatrist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="1"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Y	M	D			
Y	M	D							
A psychologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>						
A social worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>						
Another health professional	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>						

2.4. Is your patient receiving follow-up: Please specify:

At a treatment centre?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
At a health care centre?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
At a day hospital?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
In group therapy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
In individual therapy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____

**PART 3 – FOLLOW-UP AND PROGNOSIS**

3.1. Date of last visit: 

	Y			M		D	
--	---	--	--	---	--	---	--

3.2. Frequency of visits: \_\_\_\_\_

3.3. Will the patient be referred to a psychiatrist? No  Yes  Physician: \_\_\_\_\_

3.4. Patient's compliance with treatment: Excellent  Average  Poor

3.5. If you anticipate that the absence from work will extend beyond the usual period for a diagnosis of this type, please indicate the factors on which your prognosis is based.  
 \_\_\_\_\_  
 \_\_\_\_\_

3.6. Would it be helpful for your patient to receive assistance in returning to work? No  Yes

3.7. In your opinion, has the patient's condition reached an optimal level of improvement? No  Yes

3.8. Approximate length of the disability period – Number of weeks \_\_\_\_\_ or Number of months \_\_\_\_\_  
 or Returned to work on 

	Y			M		D	
--	---	--	--	---	--	---	--

 or Indeterminate

3.9. a) Is your patient fit to perform his/her regular work? No  Yes  or Any other work? No  Yes

Returned to work on 

Y		M		D	
---	--	---	--	---	--

Part-time  Full-time

If the patient is returning to work gradually, please explain why this is necessary. \_\_\_\_\_

b) Recommended return-to-work plan

Date on which the program is to begin 

Y		M		D	
---	--	---	--	---	--

Week 1: \_\_\_\_\_ days per week Date 

Y		M		D	
---	--	---	--	---	--

Week 2: \_\_\_\_\_ days per week Date 

--	--	--	--	--	--

Week 3: \_\_\_\_\_ days per week Date 

--	--	--	--	--	--

Week 4: \_\_\_\_\_ days per week Date 

--	--	--	--	--	--

**PART 4 – RATING MENTAL/FUNCTIONAL IMPAIRMENT**

- Legend:** None            0 No limitation  
Mild                    1 Slight limitation but no impairment of functional capacity  
Moderate            2 Moderate limitation but no impairment of functional capacity  
Marked                3 Significant impairment of functional capacity  
Severe                 4 Total impairment of functional capacity

Please circle the number that corresponds to your assessment, as indicated in the legend above.

1. Ability to maintain interpersonal relationships and relationships of trust	0	1	2	3	4
2. Ability to go about personal and domestic activities of daily living	0	1	2	3	4
3. Ability to maintain an interest level	0	1	2	3	4
4. Ability to understand and keep in mind instructions and carry them out	0	1	2	3	4
5. Ability to respond adequately to supervision	0	1	2	3	4
6. Ability to perform tasks requiring regular contact with others	0	1	2	3	4
7. Ability to perform tasks requiring little contact with others	0	1	2	3	4
8. Ability to perform tasks involving minimal intellectual exertion	0	1	2	3	4
9. Ability to perform complex tasks requiring a high level of reasoning, mathematical ability and speech	0	1	2	3	4
10. Ability to perform repetitive tasks at an adequate pace	0	1	2	3	4
11. Ability to perform a variety of tasks	0	1	2	3	4
12. Ability to perform tasks with consistency and rhythm	0	1	2	3	4
13. Ability to make decisions	0	1	2	3	4
14. Perseverance	0	1	2	3	4
15. Ability to supervise or manage staff	0	1	2	3	4
16. Ability to handle stress in situations requiring attention to detail and quick turnarounds	0	1	2	3	4

**PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN**

1. Last and first name: \_\_\_\_\_ Telephone: 

--	--	--	--	--	--	--	--	--	--
2. Address: \_\_\_\_\_ Fax number: 

--	--	--	--	--	--	--	--	--	--
3. General practitioner  Specialist  Other  Specify: \_\_\_\_\_

Signature: \_\_\_\_\_ Date 

Y		M		D	
---	--	---	--	---	--

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

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

**Quebec**  
**Disability Claims**  
PO Box 790, Station B  
Montreal, Quebec H3B 3K6

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

**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 tel.: \_\_\_\_\_ Work tel.: \_\_\_\_\_

**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**

1.1. Primary: \_\_\_\_\_

1.2. Secondary: \_\_\_\_\_

1.3. Objective tests performed as part of the physical examination/investigation:

Scan  MRI  ECG  Other tests/investigations performed  : \_\_\_\_\_  
 (Please attach copies of the recent test results.)

Please indicate whether the patient is: Right-handed  Left-handed

1.4. Please list the symptoms that you have personally noted.: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART 2 – TREATMENT AND VISITS**

2.1. Medication: \_\_\_\_\_

Date started	Name	Dosage	Frequency

2.2. Additional treatments (please specify the type and frequency): \_\_\_\_\_

2.3. Surgery (date and nature of the procedure): \_\_\_\_\_

2.4. Hospitalization: From \_\_\_\_\_ to \_\_\_\_\_

2.5. Specialist(s) name(s): \_\_\_\_\_

**PART 3 – MEDICAL FOLLOW-UP AND PROGNOSIS**

3.1. Date of last visit: 

Y	M	D					

 Date of next visit: 

Y	M	D					

3.2. Tests and examinations scheduled (please specify): \_\_\_\_\_

3.3. Frequency of visits: From \_\_\_\_\_ to \_\_\_\_\_ Name of hospital: \_\_\_\_\_

3.4. Referral to a specialist? No  Yes  Specialist's name: \_\_\_\_\_

3.5. Date of scheduled visit with a specialist: 

Y	M	D					

 Speciality: \_\_\_\_\_

3.6. Describe the functional limitations that prevent your patient from attending to duties or from going about usual activities.

At commencement of disability	Currently

3.7. Progress: Improving  Stable  Regressing

3.8. If you anticipate that the absence from work will extend beyond the usual period for a diagnosis of this type, please indicate the factors on which your prognosis is based.

\_\_\_\_\_  
\_\_\_\_\_

3.9. Patient's compliance with treatment: Excellent  Average  Poor

3.10. Would it be helpful for your patient to receive assistance in returning to work? No  Yes

3.11. Approximate length of the disability period: Number of weeks \_\_\_\_\_ or Number of months \_\_\_\_\_  
or Returned to work on 

Y	M	D					

 or Indeterminate

3.12. How soon will the patient be able to perform his/her regular work? \_\_\_\_\_  
or Any other work? \_\_\_\_\_

Part-time  Full-time  Gradually  Please specify: \_\_\_\_\_



