iA Financial Group

DISABILITY CLAIM
INITIAL REQUEST

GROUP INSURANCE

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
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

INSTRUCTIONS

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 **six to eight 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 8.
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) You will be informed 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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PO Box 4643, Station A
Toronto, Ontario M5W 5E3

POLICYHOLDER'S STATEMENT

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

Type of claim: Short-term disability ☐ Long-term disability ☐ Waiver of premium ☐

1. COVERAGE INFORMATION

Plan member's first name _____ Last name _____

Address _____

_____ Postal code _____

Home phone no. _____ Cell phone no. _____

Best time of the day to contact the plan member: AM ☐ PM ☐

Date of birth Y M D _____

Policy no. _____ Certificate no. _____ Class no. _____ Division no. (If applicable) _____

Department (if applicable) _____

Plan member's effective date of insurance with iA Financial Group Y M D _____ Service date Y M D _____

Original effective date of insurance Y M D _____ Date of hire Y M D _____

Benefits	Current insurance amount
Basic life insurance – Member	
Basic accidental death and dismemberment – Member	
Optional life insurance	
1. Member	
2. Spouse	
3. Children	
Long-term disability – Member	

2. WORK SCHEDULE AND EARNINGS INFORMATION

Number of hours worked in a normal week: _____

If an irregular schedule, indicate the number of hours worked for each day:

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

Gross salary prior to date of disability: $ _____ Paid monthly ☐ Biweekly ☐ Weekly ☐ Effective date Y M D _____

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

Other, please specify _____

During the period of disability, has or will the plan member receive:

Statutory holiday pay ☐ Vacation pay ☐ Pay for sick days ☐ Other ☐ _____

Amount $ _____ Period from _____ to _____

Are you able to accommodate: A gradual return to work ☐ Modified duties ☐

3. EMPLOYMENT INFORMATION

Last day worked Y M D Date returned to work (if applicable) Y M D

Accident at work Yes ☐ No ☐

Was an accident report filed with WSIB, CSST, Worksafe BC, etc.? Yes ☐ No ☐ Date filed Y M D

On the date the disability commenced was the employee: On vacation ☐ Laid off ☐ On paid leave ☐ On unpaid leave ☐

On disciplinary suspension with pay ☐ On disciplinary suspension without pay ☐ Other ☐ _____

If returned to work please specify: Full time ☐ Part time ☐ Regular duties ☐ Modified duties ☐

On the date the plan member last worked, what was the member's:

Occupation _____ Please attach a job description if available _____

How long has the member worked in this position? Number of years _____ Number of months _____

If the plan member changed jobs or assignments during the 12 months immediately before the last day worked, describe the previous position and provide the reason(s) for the change in job.

_____

_____

_____

_____

Please provide any other comments relevant to this claim:

_____

_____

4. WORK DEMANDS INFORMATION

Please complete or attach a physical demands analysis (PDA)

During the plan member's normal routine, what percentage of time is he or she required to lift or carry:

	Never	1-25%	26-50%	51-75%	76-100%
More than 10lbs/4.5 kg	☐	☐	☐	☐	☐
More than 20lbs/9.1 kg	☐	☐	☐	☐	☐
More than 50lbs/22.7kg	☐	☐	☐	☐	☐

During the plan member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Reaching above shoulder height	☐	☐	☐	☐	☐
Reaching at shoulder height	☐	☐	☐	☐	☐
Reaching below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

How long is the plan member required to remain continuously engaged in the following activities without break:

	0-30 minutes	31-60 minutes	61-90 minutes	more than 90 minutes
Continuous sitting	☐	☐	☐	☐
Continuous standing	☐	☐	☐	☐

Mental demands

During the plan member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Supervision of others	☐	☐	☐	☐	☐
Tasks with time management pressures	☐	☐	☐	☐	☐
Tasks requiring significant attention to detail	☐	☐	☐	☐	☐

5. POLICYHOLDER INFORMATION

Policyholder's name _____

Address _____ Postal code _____

Telephone no. _____ Extension _____

Email address _____

Authorized person's name _____

_____ Date Y M D _____

Signature

Name _____

Telephone no. _____ Extension _____

Email address _____

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All Other Provinces
Disability Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Type of claim: Short-term disability ☐ Long-term disability ☐ Waiver of premiums ☐

MEMBER'S STATEMENT

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

PART 1 – IDENTIFICATION

First name: _____ Last name: _____ Gender: Female ☐ Male ☐

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

Date of birth: Y M D _____ Occupation: _____ Language: French ☐ English ☐

Telephone: _____

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 board — No ☐ Yes ☐ Date Y M D
- Société de l'assurance automobile du Québec (SAAQ) or other automobile insurance organization — No ☐ Yes ☐ Date Y M D
- Human Resources and Social Development Canada (HRSDC) — No ☐ Yes ☐ Date Y M D
- Régie des rentes du Québec (RRQ): Disability pension ☐ Retirement pension ☐ — No ☐ Yes ☐ Date Y M D
- Canada Pension Plan (CPP): Disability pension ☐ Retirement pension ☐ — No ☐ Yes ☐ Date Y M D

Other (specify): _____ Date Y M D

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

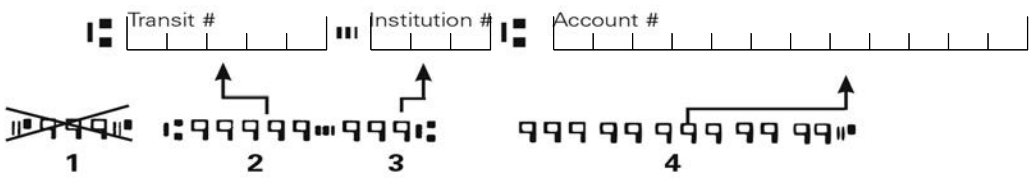
PART 7 – DIRECT DEPOSIT

Disability benefits are paid by direct deposit, i.e. electronic transfer to a bank account.

To receive your benefits:

1 Provide your bank account information

2. **Attach a void cheque** or a sample cheque generated by your financial institution's online services



1. Cheque number (do not write this number).
2. Transit number (5 digits).
3. Financial institution number (3 digits).
4. Account number up to 12 digits. The format may vary from one financial institution to another (indicate all the numbers).

PART 8 – 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 MIB Inc., 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 acting on the employer's behalf 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. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of iA Financial Group which is necessary for the purpose of assessing my disability claim;

(ii) iA Financial Group 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) iA Financial Group and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

(iv) iA Financial Group to deposit in my bank account, using the banking information I have provided above, any amounts payable in regards to a disability claim that I submit under my group insurance plan. I confirm that I am the or one of the holders of this account and that I have obtained all necessary authorizations, if applicable, to enrol in this direct deposit. I agree that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group. I understand that iA Financial Group will have no further obligation with regards to the claims paid. I also understand that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future. Furthermore, I understand and agree that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid disability claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account.

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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Montreal, Quebec H3B 3K6

All Other Provinces
Disability Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Type of claim: Short-term disability ☐ Long-term disability ☐ Waiver of premiums ☐

MEMBER IDENTIFICATION (THE MEMBER MUST COMPLETE THIS SECTION)

First name: _____ Last 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 MIB Inc., 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. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of iA Financial Group 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) within 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 ☐ A social worker? No ☐ Yes ☐

Psychologist? No ☐ Yes ☐ Another healthcare worker? 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:

Week 1: _____ days a week Date: Y M D Week 2: _____ days a week Date: Y M D

Week 3: _____ days a week Date: Y M D Week 4: _____ days a week Date: Y M D

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. First and last 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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Toronto, Ontario M5W 5E3

Type of claim: Short-term disability ☐ Long-term disability ☐ Waiver of premiums ☐

MEMBER IDENTIFICATION (The member must complete this section)

First name: _____ Last 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 MIB Inc., 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. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of iA Financial Group 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.

Date	At the beginning of disability	Currently
Y M D		
Y M D		
Y M D		

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: Plan start date: Y M D

Week 1: _____ days a week Date: Y M D Week 2: _____ days a week Date: Y M D

Week 3: _____ days a week Date: Y M D Week 4: _____ days a week Date: Y M D

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. First and last 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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