iA Financial Group

OVERAGE DEPENDENT WITH A DISABILITY QUESTIONNAIRE

GROUP INSURANCE

WHERE TO SUBMIT FORM

According to your province of residence, please submit form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1-855-884-9811

All Other Provinces
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-780-7247

1. PLAN MEMBER/DEPENDENT INFORMATION (TO BE COMPLETED BY PLAN MEMBER)

Group policy no. _____ Certificate no. _____

Plan member's first name _____ Last name _____

Dependent's first name _____ Last name _____

Dependent's date of birth Y M D

Level of education attained by dependent: Elementary _____ High school _____ College/University _____

Where does the dependent reside? ☐ With the plan member ☐ Other, please specify _____

If the patient is employed, how many hours does he/she work per week? _____ hours/week

Does one of the following individuals receive government assistance:

a) the patient? ☐ Yes ☐ No If so, which ones? _____

b) the person responsible for the patient? ☐ Yes ☐ No If so, which ones? _____

2. PATIENT INFORMATION (TO BE COMPLETED BY ATTENDING PHYSICIAN)

1. Diagnosis _____

2. Date of onset Y M D

3. Abilities affected/Limitations:

   a. Nature and degree of the physical or mental disability _____

   b. Is the patient able to live by himself/herself without supervision? ☐ Yes ☐ No

   c. Activity the patient is unable to perform:

   ☐ Bathe himself/herself ☐ Dress himself/herself ☐ Feed himself/herself ☐ Use the restroom himself/herself ☐ Move under his/her own power

4. Is the patient's condition permanent and stable or can any improvement be anticipated?

5. Is the patient taking medication related to his/her disability? ☐ Yes ☐ No If so, which ones? _____

6. Is the patient capable of working for remuneration or profit? ☐ Yes ☐ No, please indicate reasons:

Please provide a copy of any physician or other specialist consultation reports pertaining to the patient's disability.

Physician information

Name _____

Address _____ Postal code _____

Telephone _____ Fax _____

☐ General practitioner ☐ Specialist, specify _____ ☐ Other, specify _____

Physician's signature X _____ **Date** Y M D

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