F54-381A(20-10)

Disability Claim

Initial Request

INVESTED IN YOU.

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

1 877 422-6487

ia.ca

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

Quebec	**All Other Provinces**
Disability Claims	**Disability Claims**
PO Box 790, Station B	522 University Avenue, Suite 400
Montreal, Quebec H3B 3K6	Toronto, Ontario M5G 1Y7

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 **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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DISABILITY CLAIM
INITIAL REQUEST

GROUP INSURANCE

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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

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) A ___ M ___ J ___
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 Y M D ____ to Y M D ____

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 board

Société de l'assurance automobile du Québec (SAAQ) or other automobile insurance 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? Yes No
with light duties? Yes No

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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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

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 – 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.

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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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)

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

Type of claim: Invalidité de courte durée Invalidité de longue durée Exonération des primes

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): ________

PARTIE 4 – SUIVI ET PRONOSTIC

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: ________

Spécialité : ________

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: Début du plan le : 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.