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
DISABILITY CLAIM FORM
Extension of Disability

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: ____________________________ Gender: Female □ Male □
Policy no.: ____________________________ Social Insurance Number: ____________________________ Certificate no.: ____________________________
Date of birth: ____________________________ Occupation: ____________________________ Language: French □ English □
Telephone: ____________________________

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 des normes, de l’équité, de la santé et de la sécurité du travail (CNESST)
or other workers’ compensation organization
  No □ Yes □ Date ____________

– Société de l’assurance automobile du Québec (SAAQ) or other similar organization
  No □ Yes □ Date ____________

– Service Canada
  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 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. (“iA Financial Group”), its employees, reinsurers or agency acting on behalf of the Company 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: ____________
Address: ____________________________ Postal code: ____________
Home tel.: ____________________________ Work tel.: ____________________________

iA Financial Group is a business name and trademark of
Industrial Alliance Insurance and Financial Services Inc.
1-877-422-6487
ia.ca
F54-382A(21-03)
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: ___________________________  
- Gender: Female [ ] Male [ ]

- Policy no.: ___________________________  
- Social Insurance Number: ____________  
- Certificate no.: _______________________

- Date of birth: _________________________

**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. ("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: ___________________________  
- 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 V DIAGNOSIS**

1.1 Psychiatric disorder: ___________________________

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

<table>
<thead>
<tr>
<th>Signs</th>
<th>M</th>
<th>Md</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>M</th>
<th>Md</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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: ___________________________

General medical condition:  
- Diagnosis: ___________________________

- Medication prescribed: ___________________________
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:

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:

<table>
<thead>
<tr>
<th>Date started</th>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2 Treatment strategies with medication:

- Increased on __________________________ Name and dosage _______________________
- Maximised on _________________________ Name and dosage _______________________
- Combined on _________________________ Name and dosage _______________________

2.3 Please indicate whether your patient is consulting:

- A psychiatrist
  - No □ Yes □
  - Since when?

- A psychologist
  - No □ Yes □
  - Since when?

- A social worker
  - No □ Yes □
  - Since when?

- Another health professional
  - No □ Yes □
  - Since when?

2.4 Is your patient receiving follow-up:

- At a treatment centre?
  - No □ Yes □

- At a health care centre?
  - No □ Yes □

- At a day hospital?
  - No □ Yes □

- In group therapy?
  - No □ Yes □

- In individual therapy?
  - No □ Yes □

PART 3 – FOLLOW-UP AND PROGNOSIS

3.1 Date of last visit: [Y Y Y M M D 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 Y Y M M D D] or Indeterminate □
3.9 a) Is your patient fit to perform his/her regular work? No ☐ Yes ☐ Or Any other work? No ☐ Yes ☐

Return to work on: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

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: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Week 1: _________ days per week Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Week 2: _________ days per week Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Week 2: _________ days per week Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Week 2: _________ days per week Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

PART 4 – RATING MENTAL/FUNCTIONAL IMPAIRMENT

Legend: 0 No limitation

1. Slight limitation but no impairment of functional capacity

2. Moderate limitation but no impairment of functional capacity

3. Significant impairment of functional capacity

4. Total impairment of functional capacity

Please select 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: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

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: _____________

Date of birth: ___/___/____

**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. (“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: ___/___/____

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:

<table>
<thead>
<tr>
<th>Date started</th>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: [ ] Date of next visit: [ ]

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: [ ] Speciality: [ ]

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

<table>
<thead>
<tr>
<th>At commencement of disability</th>
<th>Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: [ ] 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: [ ]
PART 4 – LIMITATIONS ET RESTRICTIONS

4.1 Heart Condition (if applicable): Functional capacity according to the American Heart Association

Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐
Class 3 (Marked limitation) ☐ Class 4 (Full limitation) ☐

4.2 Functional Capacities: Please indicate how much time the patient can spend performing the following actions during a regular 8-hour workday:

- Sitting: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐
- Standing: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐
- Walking: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐

During a regular 8-hour workday, the patient is able to lift or carry: (check 1 box)

- Objects weighing more than 100 lbs. and frequently lift and carry objects weighing 50 lbs. ☐
- Objects weighing up to 100 lbs. and frequently lift and carry objects weighing up to 50 lbs. ☐
- Objects weighing up to 50 lbs. and frequently lift and carry objects weighing up to 25 lbs. ☐
- Objects weighing up to 20 lbs. and frequently lift and carry objects weighing up to 10 lbs. ☐
- Objects weighing up to 10 lbs. and occasionally carry small objects. ☐

Please indicate the actions that the patient is able to perform during a regular 8-hour workday and indicate the percentage.

<table>
<thead>
<tr>
<th>Limb Functions</th>
<th>Occasionally (0 - 33%)</th>
<th>Frequently (33 - 66%)</th>
<th>Continuously (67 - 100%)</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple grasping</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine manipulation</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keyboarding (using fingers)</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotation - Extension of the shoulder</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotation - Extension of the elbow</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of foot controls</td>
<td>LUL/RUL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LUL: Left Upper Limb  RUL: Right Upper Limb  LLL: Left Lower Limb  RLL: Right Lower Limb

4.3 Does the patient have any other limitations or restrictions not mentioned above?
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

4.4 Pregnancy Complications: If your patient is pregnant, what is the expected due date? Y Y Y Y M M D D

Please indicate the signs and symptoms, as well as the medical reasons that are preventing your patient from doing her work. (Please attach the most recent obstetrical report.)
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

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 Y Y M M D D

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