F54-381A(19-03)

Disability Claim

Initial Request

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	**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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Initial Request

GROUP INSURANCE

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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 ☐

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) Y ____ M __ D __

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 ________________ to __________________

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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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
- Human Resources and Social Development Canada (HRSDC) 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 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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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 3 ______ days a week Date Y M D

   Week 2 ______ 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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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.

At the beginning of disability Date:	Currently

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 Program start date Y M D

Week 1 ______ days a week Date Y M D Week 3 ______ days a week Date Y M D

Week 2 ______ 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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