

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

CLAIMANT'S STATEMENT	en					
1 Last Name: 2 Fi	rst Name:					
3 Contract No.: 29 880 Employee No. Employee No.	ocial Insura	ince No.:				
Complete address:						
				Postal	Code:	
6 Home telephone: ()) Other: ()	150		Exten	sion:	
7 Gender: F ☐ M ☐ BDate of birth:						
Since you stopped working, have you had any other employment? no	yes 🔲 -	→ Date	of beginnin	ıg:	П.	
If you are also the section of the section of						
If yes, specify the nature of the employment:						
Is the disability the result of an accident? no □ yes □ — Describe	the circun	nstances, ir	ncluding da	te and loca	tion.	
I) Is the disability the result of an accident? no □ yes □ → Describe			ncluding da	te and loca	tion.	
1) Have you already undergone a medical assessment related to your disabilit	y? no 🗖	nstances, ir yes 🗖		te and loca		
			IF YES	te and loca	IF DE	ENIED
1) Have you already undergone a medical assessment related to your disabilit	y? no 🗖			te and loca	IF DE Do you to appeal ti	intend nis decision?
1) Have you already undergone a medical assessment related to your disabilit	y? no 🗖	yes 🗖	IF YES		IF DE	intend
Have you already undergone a medical assessment related to your disabilit Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?
Have you already undergone a medical assessment related to your disabilit Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which payment of benefits began:	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?
Have you already undergone a medical assessment related to your disabilit Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which Payment Insurance (HRDC) Worker's Compensation	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?
Have you already undergone a medical assessment related to your disabilit Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which Employment Insurance (HRDC) Worker's Compensation Any provincial or Federal Agency Automobile Insurance Law or any other compensation program PLAN	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?
Have you already undergone a medical assessment related to your disabilit Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which Employment Insurance (HRDC) Worker's Compensation Any provincial or Federal Agency Automobile Insurance Law or any other compensation program PLAN Retirement or Pension Plan	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?
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Have you already undergone a medical assessment related to your disabilite. Have you applied for benefits under any of the following programs? PROGRAM If yes, date on which Employment Insurance (HRDC) Worker's Compensation Any provincial or Federal Agency Automobile Insurance Law or any other compensation program PLAN Retirement or Pension Plan Salary Continuance Plan	y? no 🗖	yes 🗖	IF YES		IF DE Do you to appeal ti	intend nis decision?

I hereby authorize any physician, any other professional and participating party in the health care and rehabilitation sectors as well as any public or private health or social services institution, any insurance company, as well as any insurer, any public or private institution, any information officer, any market intermediany, any employer or ex-employer, the policyholder as well as any other person who has files or personal information, especially medical information to provide to SSQ Life Insurance Company Inc. (hereinafter SSQ) or to its subsidiaries, affiliates, third party administrators and reinsurers, all information that he, she or it has, for the following purposes: to investigate and confirm the accuracy of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

I also authorize SSQ to disclose this information to the persons indicated above whenever necessary, within the framework of their activities and the processing of my file.

I also authorize SSQ and my group policyholder's medical consultants to collect, use and disclose between them information about me including details relating to diagnosis, treatment, or medication, that is relevant to my claim, for the purpose of planning and managing my rehabilitation and return to work.

In the event of death, I formally authorize the policyholder, employer, beneficiary, successors or assigns, to provide to SSQ or to its subsidiaries, affiliates, third party administrators and reinsurers, when required, all information or authorizations that make possible the processing of my file.

This authorization is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy or electronic copy of this authorization shall be as valid as the original.

Important

The following sections must be completed and signed:

By the insured

- Claimant's Statement (1 to 14)
- Upper section of Attending Physician's Statement

By the plan administrator

- Employer's Statement
- By the attending physician
- Attending Physician's Statement







PSYCHOLOGICAL ILLNESSES

NOTE: For physical illnesses, complete the form on the reverse.

Section to be completed by the patient

🚳 Last I	Name:													2	Firs	st Nam	e:														
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1.3 C	urrent sy	mpt	oms:																												
1.4 D	egree of	seve	rity:	milo	d 🔲	mod	derat	e 🗖	se	vere		wit	th ps	ycho	tic	mani	festa	atio	ons 🗖												
1.5 In	stigating	gor	omp	licati	ng fa	ctors:																									
1.6 D	ate symp	otom	s first	арр	eared	:																									
1.7 Is	this an i	nitia	occu	irren	ce? r	no 🗆	ye	s 🔲																							
If	no, spec	ify tl	ne da	te of	previ	ous c	occur	rence	:(a)																						
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5.2 Ad	dress:																														
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Gener	al practi	tione	er 🔲	Spe	ecialis	t 🔲	-	Spec	ify:																						
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PHYSICAL ILLNESSES

Group)		NOTE: F	or psycho	ological il	lnesses,	, complete t								Secti	on to	be	cor	nple	ted	by t	the p	atie
🕼 Last Name:									0	First	t Nam	e:											
3) Contract No.:		9 880 oup No.				Emplo	oyee No.		0	Socia	al Ins	urance N	umbe	r:									
ATTENDING PH	YSICI	IAN'S	STA	TEM	ENT	(To l	be com	plete	ed in	blo	ck le	tters a	nd r	eturne	d to	patie	nt)		1	J. N.			
. DIAGNOSIS																							
1.1 Primary:																							
1.2 Secondary:																							
1.3 Complications:																							
1.4 Is the illness rela	ated to	0:																					
a) an accident?			no	□ v	es 🔲	-	Specify							Dá	ate:								
b) a work-relate	ed acci	ident?					relapse		ecurr	ent					ate:								
c) an automobil	e accio	dent?					relapse								ite:								
d) pregnancy?				ye			'					ticipate	d del	iverv da	ite:								
TREATMENT														, ,									
														-									
2.1 Medication (nar	ne, do	sage, o	date o	of preso	criptio	n):																	
2.2 Do you anticipa	te:																						
a) examinations		no [) ve	es 🔲 .		Sne	cify:							D	ate:								
·	•																				'n		
b) surgery?			-	es 🔲 .			-							Da	ate:								
c) other treatme	ents?	no L	J ye	es 🔲 -	 ▶	Spe	_:£																
			-			эрс	есну:							Da	ite:								
2.3 Type of treatme	nt:		•			Spc	есну:							Da	ite:								
2.3 Type of treatme a) day-surgery:	nt:		·			эрс	есну:	o	ther	surg	ery:		ý	Da	ite:								
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a) day-surgery:b) hospitalization	n: froi	m						o	ther	surg	ery:	Nan	ne of	Da hospita									
a) day-surgery:b) hospitalizationc) clinical observant	n: froi	m						o	ther	surg	ery:	Nan	ne of										
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NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT