SSQ Financial Group

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

The information requested in items 1 to 4 should also be entered on the upper section of the "Attending Physician's Statement".

CLAIMANT'S STATEMENT

1 Last Name:

2 First Name:

3 Contract No.: 29 880 (Group No.) (Employee No.)

4 Social Insurance No.:

5 Complete address:

Postal Code:

6 Home telephone: ( ) - Other: ( ) - Extension:

7 Gender: F ☐ M ☐ 8 Date of birth:

9 Since you stopped working, have you had any other employment? no ☐ yes ☐ → Date of beginning:

If yes, specify the nature of the employment:

10 Is the disability the result of an accident? no ☐ yes ☐ → Describe the circumstances, including date and location.

11 Have you already undergone a medical assessment related to your disability? no ☐ yes ☐

12 Have you applied for benefits under any of the following programs?

PROGRAM	NO	IF YES		IF DENIED	
		Pending	Accepted	Declined	Do you intend to appeal this decision? yes	no
Employment Insurance (HRDC) — If yes, date on which payment of benefits began:	☐	☐	☐	☐	☐	☐
Worker's Compensation	☐	☐	☐	☐	☐	☐
Any provincial or Federal Agency	☐	☐	☐	☐	☐	☐
Automobile Insurance Law or any other compensation program	☐	☐	☐	☐	☐	☐
PLAN Retirement or Pension Plan	☐	☐	☐	☐	☐	☐
Salary Continuance Plan	☐	☐	☐	☐	☐	☐
Health or Welfare Plan	☐	☐	☐	☐	☐	☐
Any other group insurance plan:	☐	☐	☐	☐	☐	☐

NOTE: PLEASE INCLUDE COPIES OF ANY DOCUMENTS RECEIVED FROM THESE SOURCES, INCLUDING ANY BENEFIT PAYMENT STATEMENTS.

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 intermediary, 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

13 Signature

14 Date

MANION WILKINS & ASSOCIATES LTD • 500 - 21 FOUR SEASONS PLACE • ETOBICOKE ONTARIO • M9B 0A5
TEL.: 1-800-663-7849 (Toll-free) • 416-234-3513 • Fax: 416-234-0127
acclaims@manionwilkins.com

SSQ Financial Group

PSYCHOLOGICAL ILLNESSES

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

Section to be completed by the patient

1 Last Name: 2 First Name:

3 Contract No.: 29 880 Group No. Employee No. 4 Social Insurance Number:

ATTENDING PHYSICIAN'S STATEMENT (To be completed in block letters and returned to patient)

1. DIAGNOSIS

1.1 Primary:

1.2 Secondary:

1.3 Current symptoms:

1.4 Degree of severity: mild ❑ moderate ❑ severe ❑ with psychotic manifestations ❑

1.5 Instigating or complicating factors:

1.6 Date symptoms first appeared:

1.7 Is this an initial occurrence? no ❑ yes ❑

If no, specify the date of previous occurrence(s):

2. TREATMENT

2.1 Medication (name, dosage, date of prescription):

2.2 Is the patient seeing a psychotherapist or other practitioner? no ❑ yes ❑

If yes, name of practitioner: Specialization:

2.3 a) Hospitalization: from to Name of hospital:

b) Clinical observation: number of hours:

3. FOLLOW-UP

3.1 Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

3.2 Frequency of follow-up for this disability:

3.3 Has the patient been referred for psychiatric examination or treatment? no ❑ yes ❑ Name of physician:

Please attach a copy of your clinical notes and any test results or consultant reports available.

4. PROGNOSIS

4.1 In your opinion, is this patient totally incapable of performing his/her normal work duties? no ❑

yes ❑ → from to inclusive.

4.2 Anticipated date of return to work:

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: First Name:

5.2 Address:

5.3 Licence No.: Telephone: ( ) -

General practitioner ❑ Specialist ❑ → Specify:

Signature Date:

NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT

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SSQ Financial Group

PHYSICAL ILLNESSES

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

Section to be completed by the patient

1 Last Name: 2 First Name:

3 Contract No.: 29 880 Group No. Employee No. 4 Social Insurance Number:

ATTENDING PHYSICIAN'S STATEMENT (To be completed in block letters and returned to patient)

1. DIAGNOSIS

1.1 Primary:

1.2 Secondary:

1.3 Complications:

1.4 Is the illness related to:

a) an accident? no ❑ yes ❑ → Specify: Date:

b) a work-related accident? no ❑ yes ❑ → relapse ❑ recurrent ❑ Date:

c) an automobile accident? no ❑ yes ❑ → relapse ❑ recurrent ❑ Date:

d) pregnancy? no ❑ yes ❑ Anticipated delivery date:

2. TREATMENT

2.1 Medication (name, dosage, date of prescription):

2.2 Do you anticipate:

a) examinations? no ❑ yes ❑ → Specify: Date:

b) surgery? no ❑ yes ❑ → Specify: Date:

c) other treatments? no ❑ yes ❑ → Specify: Date:

2.3 Type of treatment:

a) day-surgery: other surgery:

b) hospitalization: from to Name of hospital:

c) clinical observation: number of hours:

3. FOLLOW-UP

3.1 Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

3.2 Frequency of follow-up:

3.3 Referral to another physician? no ❑ yes ❑ Name of physician: Specialty:

Please attach a copy of your clinical notes and any test results or consultant reports available.

4. PROGNOSIS

4.1 In your opinion, is this patient totally incapable of performing his/her normal work duties? no ❑

yes ❑ → from to inclusive.

4.2 Anticipated date of return to work:

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: First Name:

5.2 Address:

5.3 Licence No.: Telephone: ( ) -

General practitioner ❑ Specialist ❑ → Specify:

Signature Date:

NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT

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