

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 4 Social Insurance No.: \_\_\_\_\_  
Group No. Employee 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	If yes, date on which payment of benefits began: _____	NO	IF YES			IF DENIED	
		<input type="checkbox"/>	Pending	Accepted	Declined	Do you intend to appeal this decision?	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	yes	no
Employment Insurance (HRDC)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any provincial or Federal Agency		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automobile Insurance Law or any other compensation program		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PLAN</b>							
Retirement or Pension Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salary Continuance Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health or Welfare Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other group insurance plan:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I hereby certify that the above information is true, accurate and complete.

Solely for purposes of processing this benefit claim, I authorize the following:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer;
- any other insurance or reinsurance companies;
- any public or parapublic body, such as EI, Worker's compensation, Provincial automobile insurance;
- any other person or institution.

who may have information regarding my claim, particularly any medical information, to communicate such to SSQ, Life Insurance Company inc. (hereinafter SSQ) or its agent. In so doing, I discharge them of their obligations of confidentiality and authorize them to provide SSQ or its agent with any information requested.

Moreover, I hereby authorize SSQ or its agent to submit my file to one or more physicians chosen by SSQ or its agent for the purpose of evaluation.

Photocopies of this document shall have the same effect 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 \_\_\_\_\_

**EMPLOYER'S STATEMENT**

1 Contract No.: 29 880 \_\_\_\_\_  
Group No. Employee No.

2 Last Name of employee: \_\_\_\_\_

3 First Name of employee: \_\_\_\_\_

4 Base: \_\_\_\_\_

5 Date of hire: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

6 Previous 3 months gross earnings available at time of book off:

1) 

		Y				M		
--	--	---	--	--	--	---	--	--

 \$ \_\_\_\_\_

2) 

		Y				M		
--	--	---	--	--	--	---	--	--

 \$ \_\_\_\_\_

3) 

		Y				M		
--	--	---	--	--	--	---	--	--

 \$ \_\_\_\_\_

If Minimum Monthly Guarantee (MMG) is provided, please indicate actual earnings and why actual earnings are below MMG.

Hourly rate of pay \$ \_\_\_\_\_ /hr.

7 Personal exemptions: Federal TD1 \$ \_\_\_\_\_ Provincial TP1015.3 \$ \_\_\_\_\_

8 Last day worked: 

		Y				M			D
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9 First flight missed: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

10 Has the employee returned to work? no  yes  → Date: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

11 Does the disability result from a work-related accident?  an occupational illness?

12 Does the disability coincide with, or is the employee returning from:

a dismissal? no  yes  → Date: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

a lay-off? no  yes  → from 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

 to 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

 Date of notification: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

an elimination of a position? no  yes  → Date: 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

an unpaid leave? no  yes  → from 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

 to 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

13 other: specify \_\_\_\_\_ from 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

 to 

		Y				M			D
--	--	---	--	--	--	---	--	--	---

I hereby certify that the above information is true, accurate and complete.

14 \_\_\_\_\_ Title: \_\_\_\_\_ 15 Date: 

		Y				M			D
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Signature of authorized person

1 Last Name: \_\_\_\_\_ 2 First Name: \_\_\_\_\_  
 3 Contract No.: 29 880      Employee No. \_\_\_\_\_ 4 Social Insurance Number: \_\_\_\_\_  
Group No.

**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: | | Y | | | M | | | D | |  
 1.7 Is this an initial occurrence? no  yes   
 If no, specify the date of previous occurrence(s): | | Y | | | M | | | D | | | Y | | | M | | | D | | | Y | | | M | | | D | |

**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: | | Y | | | M | | | D | |

**5. PHYSICIAN IDENTIFICATION**

5.1 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 5.2 Address: \_\_\_\_\_  
 5.3 Licence No.: \_\_\_\_\_ Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 General practitioner  Specialist  → Specify: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: | | Y | | | M | | | D | |

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

