

Disability Insurance Benefits Application

Section 1 Instructions

Please print clearly

The following sections must be completed and signed:

- By Plan Member**
Section 2 – Claimant’s Statement
Section 4/5 – Plan Member Information at the top of the Attending Physician’s Statement
- By the Plan Administrator**
Section 3 – Employer’s Statement
- By the Attending Physician**
Section 4/5 – Attending Physician’s Statement

Section 2 Claimant’s Statement

Name of Employee _____

<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (yyyy/mm/dd)	Identification No.	Social Insurance No.
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Employee’s Address _____

Home Telephone	Work Telephone
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Since you stopped working, have you had any other employment? Yes No
If yes, please provide the following information:

Start Date	Nature of Employment

Is the disability the result of an accident? Yes No
If yes, please describe the circumstances, including date and location _____

Have you already undergone a medical assessment related to your disability? Yes No

Have you applied for benefits under any of the following programs or plans? If yes, please include copies of any documents received from these sources, including any benefit payment statements.	NO		IF YES		IF REFUSED	
			Pending	Accepted	Refused	Do you intend to appeal this decision?
						Yes No
Employment Insurance (EI) If yes, please insert date payment of benefits began (yyyy/mm/dd)	<input type="checkbox"/> <input type="checkbox"/>					
Workers’ Compensation	<input type="checkbox"/> <input type="checkbox"/>					
Provincial or Federal Government Agency	<input type="checkbox"/> <input type="checkbox"/>					
Automobile Insurance Law or Any Other Compensation Program	<input type="checkbox"/> <input type="checkbox"/>					
Retirement or Pension Plan	<input type="checkbox"/> <input type="checkbox"/>					
Salary Continuance Plan	<input type="checkbox"/> <input type="checkbox"/>					
Health or Welfare Plan	<input type="checkbox"/> <input type="checkbox"/>					
Any Other Group Insurance Plan (specify):	<input type="checkbox"/> <input type="checkbox"/>					

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

For the purposes of reviewing my benefit claim, I authorize the following:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer or the former employer;
- any other insurance or reinsurance company;
- any public or parapublic organizations body, such as EI, Workers’ Compensation, provincial automobile insurance;
- any other person or institution;

who may have information regarding my claim, particularly any medical information, to communicate such information to SSQ, Life Insurance Company Inc. (“SSQ”) or ENCON Group Inc. (“ENCON”). 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 ENCON to submit my file to one or more physicians chosen by SSQ or ENCON for the purposes of evaluation.

A copy of this authorization shall be as valid as the original.

Please sign here

Employee Signature _____	Date (yyyy/mm/dd) _____
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Section 3 Employer's Statement

Please print clearly

Name of Plan Administrator	Title
Name of Employer	Work Telephone
Name of Employee	Identification No.
Employee Occupation	<input type="checkbox"/> Application for Weekly Indemnity <input type="checkbox"/> Application for Long Term Disability

Description of Job Duties

Weekly Salary at Start of Disability

Gross \$ _____ Net* \$ _____
* as defined in the group insurance contract

Personal Exemptions

Federal \$ _____ Provincial \$ _____

Employee Classification

Full-time
 On call
 Part-time – % of time worked: _____
 Other (specify): _____

Regular Work Week

from _____ to _____

Number of Hours Worked in a Regular Week

Workday

from _____ to _____

Last Day Worked (yyyy/mm/dd)	Number of Hours Worked
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Date of First Day of Absence From Work (yyyy/mm/dd)	Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Date (yyyy/mm/dd)
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To be completed for employees with variable work schedules

Indicate in the appropriate boxes the number of hours for each day: 1st – As of the last day worked
 2nd – On return to work

Year	Month	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		

Does the disability coincide with

Dismissal Yes No Date (yyyy/mm/dd) _____

Layoff Yes No Date (yyyy/mm/dd) from _____ to _____ Date of Notification _____

Elimination of a position Yes No Date (yyyy/mm/dd) _____

Unpaid leave Yes No Date (yyyy/mm/dd) from _____ to _____

Other (specify): _____ Date (yyyy/mm/dd) from _____ to _____

During the period of disability, have you made any payments to this employee? Yes No

If yes, specify the nature, the period and the amount of any such payments (e.g., holiday, sick-leave):

Nature	Period	Amount
		\$ _____

Is there any other information concerning the present claim that we should be aware of? Yes No

If yes, please specify

If the employee is capable of performing a function with this condition, is there any work available in your organization? Yes No

If yes, please specify

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

Employer Signature	Date (yyyy/mm/dd)
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Please sign here

Note: For physical illness, please complete Section 5

Plan Member Information

Name of Employee

Date of Birth (yyyy/mm/dd)

Identification No.

Social Insurance No.

Note: The Plan Member is responsible for any costs related to the completion of this form.

Attending Physician's Statement

Diagnosis

Principal

Secondary

Current Symptoms

Degree of Severity of All Symptoms

Mild Moderate Severe With Psychotic Problems

Problems Contributing to the Interruption of Work

Marital/Family Life Loss of Employment or Layoff Alcohol or Drug Abuse and/or Gambling Problems
 Personal or Interpersonal Problems Professional Problems Other:

Indicate previous actions taken by patient for illnesses or associated symptoms diagnosed

underwent medical treatments consulted another physician took medication was hospitalized underwent examinations

Specify the periods (yyyy/mm/dd)

Treatment

Medication (name of drug and dosage)

Is the patient consulting

a psychiatrist? Yes No

a social worker? Yes No

a psychologist? Yes No

another health care provider? Yes No

If yes, provide the name of the professional

Hospitalization

Name of Hospital

from _____ to _____

Follow-up and Prognosis

Date of First Consultation for this Disability (yyyy/mm/dd)

Date of Next Consultation (yyyy/mm/dd)

Dates of Other Consultations (yyyy/mm/dd)

Follow-up Frequency

Will the patient be referred to a psychiatrist?

Yes No

If yes, please provide name of psychiatrist

Approximate Duration of Disability

Days Weeks Unspecified

Date of Return to Work (yyyy/mm/dd)

How long before the patient will be able to return to work?

Days Weeks

Part-time Gradual Return

Full-time Specify:

Other Questions

Physician Information

Name of Physician

Work Telephone

License No.

General Practitioner

Specialist (specify):

Physician Signature, M.D.

Date (yyyy/mm/dd)

Please sign here

Note: For psychological illness, please complete Section 4

Plan Member Information

Name of Employee _____

Date of Birth (yyyy/mm/dd) _____

Identification No. _____

Social Insurance No. _____

Note: The Plan Member is responsible for any costs related to the completion of this form.

Attending Physician's Statement

Diagnostic

Principal _____

Secondary _____

Complications _____

Indicate previous actions taken by patient for illnesses or associated symptoms diagnosed

underwent medical treatments consulted another physician took medication was hospitalized underwent examinations

Specify the periods (yyyy/mm/dd) _____

Is the disability related to

an accident? an illness? an occupational accident? an automobile accident? Date of Event (yyyy/mm/dd): _____

pregnancy? Expected Date of Delivery (yyyy/mm/dd): _____

a preventative withdrawal from work?

Describe functional limitations that prevent the patient from carrying out professional duties or usual activities

At the Onset of Disability (yyyy/mm/dd) _____

Currently _____

Treatment

Medication (name of drug and dosage) _____

Has the patient undergone or will the patient undergo

Examinations or tests? Yes No

Specify: _____

Surgery? Yes No Day Surgery

Type: _____ Date (yyyy/mm/dd): _____

Surgical Procedure: _____

Other treatments? Yes No

Specify: _____

Hospitalization? Yes No

From _____ to _____

Name of Hospital: _____

A short stay under observation? Yes No

Number of Hours: _____

Follow-up and Prognosis

Date of First Consultation for this Disability (yyyy/mm/dd) _____

Date of Next Consultation (yyyy/mm/dd) _____

Dates of Other Consultations (yyyy/mm/dd) _____

Follow-up Frequency _____

Will the patient be referred to another physician?

Yes No

If yes, please provide name of physician _____

Approximate Duration of Disability

Days Weeks Unspecified

Date of Return to Work (yyyy/mm/dd) _____

How long before the patient will be able to return to work?

Days Weeks

Part-time Gradual Return

Full-time Specify: _____

Other Questions

Physician Information

Name of Physician _____

Work Telephone _____

License No. _____

General Practitioner

Specialist (specify): _____

Physician Signature, M.D. _____

Date (yyyy/mm/dd) _____

Please sign here