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

❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Identification No.	Social Insurance No. (SIN)

Employee Address

Home Telephone | Work Telephone

Since you stopped working, have you had any other employment? ❑ Yes ❑ No

If yes, provide the following information:

Start Date	Nature of Employment

Is the disability the result of an accident? ❑ Yes ❑ No

If yes, describe the circumstances, including date and location.

Have you already undegone a medical assessment related to you 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, insert date payment of benefits began (yyyy/mm/dd)	❑	❑	❑	❑	❑	❑
Worker's Compensation	❑	❑	❑	❑	❑	❑
Provincial or Federal Government Agency	❑	❑	❑	❑	❑	❑
Automobile Insurance Law or Any Other Compensation Program	❑	❑	❑	❑	❑	❑
Retirement or Pension Plan	❑	❑	❑	❑	❑	❑
Salary Continuance Plan	❑	❑	❑	❑	❑	❑
Health or Welfare Plan	❑	❑	❑	❑	❑	❑
Any Other Group Insurance Plan (specify):	❑	❑	❑	❑	❑	❑

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 companies;
- any public or parapublic organizations 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 information to SSQ, Life Insurance Company Inc. (hereinafter SSQ) or ENCON Group Inc. 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.

Photocopies of this document shall be considered as valid as the original.

Employee's Signature | Date (yyyy/mm/dd)

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

Description of Tasks

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

Date of First Day of Absence from Work (yyyy/mm/dd) | Has the employee returned to work? ❑ Yes ❑ No
Date (yyyy/mm/dd)

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 organiztion? ❑ Yes ❑ No

If yes, please specify

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

Please sign here

Employer Signature Date (yyyy/mm/dd)

Section 4 Attending Physician's Statement – Psychological Illness

Please print clearly

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. (SIN)

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 from to Name of Hospital

Follow-up and Prognosis

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

Dates of Other Consultations (yyyy/mm/dd) Follow-up Frequency

Will the patient be referred to another psychiatrist? ❑ Yes ❑ No 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 ❑ Full-time ❑ Gradual Return ❑ Specify:

Other Questions

Physician Information

Name of Physician	Work Telephone
License No.	❑ General Practitioner ❑ Specialist (specify):
Signature	Date (yyyy/mm/dd)

Section 5 Attending Physician's Statement – Physical Illness

Please print clearly

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. (SIN)

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? ❑ Yes ❑ No Expected Date of Delivery (yyyy/mm/dd): _____

a preventative withdrawal from work? ❑ Yes ❑ No

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: _____

Surgical Procedure: _____

Other treatments? ❑ Yes ❑ No Specify: _____

Hospitalization? ❑ Yes ❑ No From _____ to _____

Name of Hospital: _____

A short stay under observation? ❑ Yes ❑ No No. of Hours:

Follow-up and Prognosis

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