iA Financial Group

DISABILITY CLAIM FORM
Extension of Disability

GROUP INSURANCE

According to your region, please submit the completed form to:

Quebec
Disability Claims
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
Disability Claims
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

INSTRUCTIONS

In order to properly complete the form, each party should follow the instructions below.

MEMBER

1. Please complete the “Member’s Statement” and ensure that you answer all questions to avoid file review delays. Don’t forget to sign the “Member Confirmation/Authorization” in Part 4.
2. Please ensure that your attending physician completes the medical declaration that applies to your condition (physical and/or psychological). You must also complete the “Member Identification” section AND sign the “Member Authorization” at the top of the physician’s declaration.
3. Please enclose a photocopy of the benefit statement from the government plan under which you are receiving benefits (Régie des rentes du Québec, Canada Pension Plan, workers’ compensation, auto insurance, victim of criminal act compensation, etc.).
4. Attach a copy of all correspondence received from the applicable government plan mentioned in Number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of your file.

Note:

a. It is your responsibility to pay any fees that are applicable to have this form completed by your attending physician.

b. During the course of a disability, it is very important to read the comments provided on your benefit cheque stubs. These comments are to inform you of any decisions that have been made as well as to request any additional information that may be required in case of an extended disability.

c. Please return the entire document to the address above. Do not detach any pages.

ATTENDING PHYSICIAN

1. Please complete the medical declaration that applies to the condition of your patient (physical and/or psychological) and ensure that you answer all questions to avoid file review delays.
2. Please attach any other documentation pertinent to the analysis of the request (such as the results of various examinations carried out and specialist reports) to the form.

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Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

MEMBER'S STATEMENT

TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

PART 1 – IDENTIFICATION

Last name:_____ First name:_____ Gender: Female ☐ Male ☐

Policy no.: Social Insurance Number: Certificate no.:

Date of birth: (Y Y Y Y M M D D) Occupation: _____ Language: French ☐ English ☐

Telephone:

PART 2 – CURRENT SITUATION

1. Since the date of the initial request: Are you confined to your home? No ☐ Yes ☐
Confined to your bed? No ☐ Yes ☐
Hospitalized? No ☐ Yes ☐

2. Please describe all your symptoms including their severity and frequency:_____

_____

3. Describe your current activities of daily living since going on sick leave: _____

_____

4. When do you expect to return to work full or part time? (Y Y Y Y M M D D)

PART 3 – INCOME FROM OTHER SOURCES

Have you applied or will you be applying for benefits from any of the following sources:

– Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) or other workers' compensation organization No ☐ Yes ☐ Date (Y Y Y Y M M D D)
– Société de l'assurance automobile du Québec (SAAQ) or other similar organization No ☐ Yes ☐ Date
– Service Canada No ☐ Yes ☐ Date
– Régie des rentes du Québec (RRQ): Disability pension ☐ Retirement pension ☐ No ☐ Yes ☐ Date
– Canada Pension Plan (CPP): Disability pension ☐ Retirement pension ☐ No ☐ Yes ☐ Date
– Other (specify): _____ Date

If you have already applied for benefits, please provide a copy of all correspondence, including the decision, if applicable.

PART 4 – MEMBER CONFIRMATION/AUTHORIZATION

I CONFIRM that the statements provided in the Member's Statement and all statements provided in any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge. I AGREE that all such statements form the basis for any benefits approved as a result of this claim.

I HEREBY AUTHORIZE:

(i) any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of the Company which is necessary for the purpose of assessing my disability claim;

(ii) iA Financial Group to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and

(iii) iA Financial Group and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

A photocopy of this Confirmation/Authorization shall be as valid as the original.

This Confirmation/Authorization is valid only for this disability claim.

Member's signature: _____ Date: (Y Y Y Y M M D D)

Address:_____ Postal code:

Home tel.: Work tel.:

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522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

MEMBER IDENTIFICATION (The member must complete this section)

Last name:_____ First name:_____ Gender: Female ☐ Male ☐

Policy no.: | | | | | | | | | | Social Insurance Number: | | | | | | | | | Certificate no.: | | | | | | | | | | | | | | | | | | | | |

Y Y Y Y M M D D

Date of birth: | | | | | | | |

MEMBER AUTHORIZATION

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of iA Financial Group which is necessary for the purpose of assessing my disability claim.

A photocopy of this Authorization shall be as valid as the original.

This Authorization is valid only for this disability claim.

Member's signature: _____ Date: Y Y Y Y M M D D | | | | | | | | |

Address:_____ Postal code: | | | | | | |

Home tel.: | | | | | | | | | | Work tel.: | | | | | | | | | |

ATTENDING PHYSICIAN'S STATEMENT – PSYCHOLOGICAL ILLNESS

Please print and give to the patient.

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST.

PART 1 – DIAGNOSIS

1. DSM V DIAGNOSIS

1.1 Psychiatric disorder: _____

_____

1.2 Please describe the signs and symptoms, indicating the frequency and the degree of severity of each one:
M = Mild Md = Moderate S = Severe

Signs	M	Md	S	Symptoms	M	Md	S
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐

Are there any associated personality disorders? No ☐ Yes ☐ Specify:_____

Are there any associated drug addiction, alcoholism or gambling problems? No ☐ Yes ☐

If so, please specify:_____

General medical condition: – Diagnosis: _____

_____

– Medication prescribed: _____

_____

Associated psychosocial problems (in the past 12 months):

☐ Personal or interpersonal problems ☐ Alcohol or drug abuse and/or gambling problems

☐ Marital or family problems

☐ Job loss or layoff ☐ Work-related problems

☐ Other, please specify: _____

Global assessment of functioning – Highest level in the past year: GAF score (0-100) _____

– Highest level in the past year: GAF score (0-100) _____

PART 2 – TREATMENT AND VISITS

2.1 Medication: _____

Date started	Name	Dosage	Frequency

2.2 Treatment strategies with medication:

- Increased on _____ Name and dosage _____
- Maximized on _____ Name and dosage _____
- Combined on _____ Name and dosage _____

2.3 Please indicate whether your patient is consulting: Since when? Y Y Y Y M M D D

A psychiatrist	No ☐	Yes ☐	
A psychologist	No ☐	Yes ☐	
A social worker	No ☐	Yes ☐	
Another health professional	No ☐	Yes ☐	

2.4 Is your patient receiving follow-up: Please specify:

At a treatment centre?	No ☐	Yes ☐	_____
At a health care centre?	No ☐	Yes ☐	_____
At a day hospital?	No ☐	Yes ☐	_____
In group therapy?	No ☐	Yes ☐	_____
In individual therapy?	No ☐	Yes ☐	_____

PART 3 – FOLLOW-UP AND PROGNOSIS

3.1 Date of last visit: Y Y Y Y M M D D

3.2 Frequency of visits: _____

3.3 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Physician: _____

3.4 Patient's compliance with treatment: Excellent ☐ Average ☐ Poor ☐

3.5 If you anticipate that the absence from work will extend beyond the usual period for a diagnosis of this type, please indicate the factors on which your prognosis is based.

_____

_____

3.6 Would it be helpful for your patient to receive assistance in returning to work? No ☐ Yes ☐

3.7 In your opinion, has the patient's condition reached an optimal level of improvement? No ☐ Yes ☐

3.8 Approximate length of the disability period – Number of weeks _____ or Number of months _____

or Returned to work on Y Y Y Y M M D D or Indeterminate ☐

3.9 a) Is your patient fit to perform his/her regular work? No ☐ Yes ☐ Or Any other work? No ☐ Yes ☐

Returned to work on: Y Y Y Y M M D D

Part-time ☐ Full-time ☐

If the patient is returning to work gradually, please explain why this is necessary: _____

_____

b) Recommended return-to-work plan Date on which the program is to begin: Y Y Y Y M M D D

Week 1: _____ days per week Date: Y Y Y Y M M D D

Week 2: _____ days per week Date:

Week 3: _____ days per week Date:

Week 4: _____ days per week Date:

PART 4 – RATING MENTAL/FUNCTIONAL IMPAIRMENT

Legend: 0 No limitation
1 Slight limitation but no impairment of functional capacity
2 Moderate limitation but no impairment of functional capacity
3 Significant impairment of functional capacity
4 Total impairment of functional capacity

Please select the number that corresponds to your assessment, as indicated in the legend above.

1. Ability to maintain interpersonal relationships and relationships of trust	0	1	2	3	4
2. Ability to go about personal and domestic activities of daily living	0	1	2	3	4
3. Ability to maintain an interest level	0	1	2	3	4
4. Ability to understand and keep in mind instructions and carry them out	0	1	2	3	4
5. Ability to respond adequately to supervision	0	1	2	3	4
6. Ability to perform tasks requiring regular contact with others	0	1	2	3	4
7. Ability to perform tasks requiring little contact with others	0	1	2	3	4
8. Ability to perform tasks involving minimal intellectual exertion	0	1	2	3	4
9. Ability to perform complex tasks requiring a high level of reasoning, mathematical ability and speech	0	1	2	3	4
10. Ability to perform repetitive tasks at an adequate pace	0	1	2	3	4
11. Ability to perform a variety of tasks	0	1	2	3	4
12. Ability to perform tasks with consistency and rhythm	0	1	2	3	4
13. Ability to make decisions	0	1	2	3	4
14. Perseverance	0	1	2	3	4
15. Ability to supervise or manage staff	0	1	2	3	4
16. Ability to handle stress in situations requiring attention to detail and quick turnarounds	0	1	2	3	4

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. Last and first name: _____ Telephone:

2. Address: _____ Fax number:

3. General practitioner ☐ Specialist ☐ Other ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.

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Toronto, Ontario M5G 1Y7

Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

MEMBER IDENTIFICATION (The member must complete this section)

Last name:_____ First name: _____

Policy no.: | | | | | | | | | | Social Insurance Number: | | | | | | | | | Certificate no.: | | | | | | | | | | | | | | | | | | | | |

Date of birth: Y Y Y Y M M D D | | | | | | | |

MEMBER AUTHORIZATION

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, reinsurers or agency acting on behalf of iA Financial Group which is necessary for the purpose of assessing my disability claim.

A photocopy of this Authorization shall be as valid as the original.

This Authorization is valid only for this disability claim.

Member's signature: _____ Date: Y Y Y Y M M D D | | | | | | | |

Address:_____ Postal code: | | | | | | |

Home tel.: | | | | | | | | | | Work tel.: | | | | | | | | | |

ATTENDING PHYSICIAN'S STATEMENT – PHYSICAL ILLNESS

Please print and give to the patient.

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST.

PART 1 – DIAGNOSIS

1.1 Primary: _____

1.2 Secondary:_____

1.3 Objective tests performed as part of the physical examination/investigation:

Scan ☐ MRI ☐ ECG ☐ Other tests/investigations performed ☐: _____

(Please attach copies of the recent test results.)

Please indicate whether the patient is: Right-handed ☐ Left-handed ☐

1.4 Please list the symptoms that you have personally noted: _____

_____

_____

_____

_____

_____

PART 2 – TREATMENT AND VISITS

2.1 Medication: _____

Date started	Name	Dosage	Frequency

2.2 Additional treatments (please specify the type and frequency):_____

2.3 Surgery (date and nature of the procedure):_____

2.4 Hospitalization: From Y Y Y Y M M D D to Y Y Y Y M M D D

2.5 Specialist(s) name(s):_____

PART 3 – MEDICAL FOLLOW-UP AND PROGNOSIS

3.1. Date of last visit: Y Y Y Y M M D D Date of next visit: Y Y Y Y M M D D

3.2 Tests and examinations scheduled (please specify): _____

3.3 Frequency of visits: From Y Y Y Y M M D D to Y Y Y Y M M D D

Name of hospital: _____

3.4 Referral to a specialist? No ☐ Yes ☐ Specialist's name: _____

3.5 Date of scheduled visit with a specialist: Y Y Y Y M M D D Speciality: _____

3.6 Describe the functional limitations that prevent your patient from attending to duties or from going about usual activities.

At commencement of disability	Currently

3.7 Progress: Improving ☐ Stable ☐ Regressing ☐

3.8 If you anticipate that the absence from work will extend beyond the usual period for a diagnosis of this type, please indicate the factors on which your prognosis is based.

_____

_____

3.9 Patient's compliance with treatment: Excellent ☐ Average ☐ Poor ☐

3.10 Would it be helpful for your patient to receive assistance in returning to work? No ☐ Yes ☐

3.11 Approximate length of the disability period: Number of weeks _____ or Number of months _____

or Returned to work on: Y Y Y Y M M D D or Indeterminate ☐

3.12 How soon will the patient be able to perform his/her regular work? _____

or Any other work? _____

Part-time ☐ Full-time ☐ Gradually ☐ Please specify: _____

PART 4 – LIMITATIONS ET RESTRICTIONS

4.1 Heart Condition (if applicable): Functional capacity according to the American Heart Association

Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐

Class 3 (Marked limitation) ☐ Class 4 (Full limitation) ☐

4.2 Functional Capacities: Please indicate how much time the patient can spend performing the following actions during a regular 8-hour workday:

- Sitting: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐
- Standing: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐
- Walking: 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐

During a regular 8-hour workday, the patient is able to lift or carry: (check 1 box)

- Objects weighing more than 100 lbs. and frequently lift and carry objects weighing 50 lbs. ☐
- Objects weighing up to 100 lbs. and frequently lift and carry objects weighing up to 50 lbs. ☐
- Objects weighing up to 50 lbs. and frequently lift and carry objects weighing up to 25 lbs. ☐
- Objects weighing up to 20 lbs. and frequently lift and carry objects weighing up to 10 lbs. ☐
- Objects weighing up to 10 lbs. and occasionally carry small objects. ☐

Please indicate the actions that the patient is able to perform during a regular 8-hour workday and indicate the percentage.

Limb Functions		Occasionally (0 - 33%)	Frequently (33 - 66%)	Continuously (67 - 100%)	Never
Simple grasping	LUL / RUL				
Fine manipulation	LUL / RUL				
Keyboarding (using fingers)	LUL / RUL				
Rotation - Extension of the shoulder	LUL / RUL				
Rotation - Extension of the elbow	LUL / RUL				
Use of foot controls	LUL / RUL				

LUL: Left Upper Limb RUL: Right Upper Limb LLL: Left Lower Limb RLL: Right Lower Limb

4.3 Does the patient have any other limitations or restrictions not mentioned above?

_____

_____

4.4 Pregnancy Complications: If your patient is pregnant, what is the expected due date? Y Y Y Y M M D D

Please indicate the signs and symptoms, as well as the medical reasons that are preventing your patient from doing her work. (Please attach the most recent obstetrical report.)

_____

_____

PART 5 – IDENTIFICATION OF THE ATTENDING PHYSICIAN

1. Last and first name: _____ Telephone:

2. Address: _____ Fax number:

3. General practitioner ☐ Specialist ☐ Other ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.