# DISABILITY BENEFITS CLAIM
Initial Claim

**Nature of Claim:** ☐ Disability – Income Replacement ☐ Disability – Office Overhead ☐ Waiver of Premiums

**PLEASE ANSWER ALL THE QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES TO MAKE SURE YOUR CLAIM IS PROCESSED AS QUICKLY AS POSSIBLE.**

## Claimant Identification

Policy No. | Certificate No. | Sogemec No. | Licence No.

Specialty

Last Name | First Name | ☐ Female ☐ Male Sex

Address

City | Province | Postal Code

Main Phone

☐ I authorize SSQ, Life Insurance Company Inc., herein SSQ Insurance, to leave messages about my disability file on my voice mail.

Email Address*

Y Y Y Y M M D D Date of Birth

*Provide this information only if you authorize SSQ Insurance to contact you by email.

## Financial Information

Business structure: ☐ Self-employed ☐ Incorporated (inc.) ☐ Partnership (please provide proof of your stake) ☐ Employee

Please indicate the accounting method used**:

☐ Cash accounting (revenues and expenses recorded when actually received or paid)

☐ Accrual accounting (revenues and expenses recorded when transaction occurs)

**Cannot be modified while on disability leave

1. Do you have disability income replacement and/or office overhead insurance (individual, group or professional order) with another insurer? If so, please complete the following table:

| Insurer | Policy No. | Product Type | Elimination Period | Monthly Benefit | Effective Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

☐ I do not have any other disability insurance.

2. Do you have other sources of income? ☐ No ☐ Yes – Check one of the following:

☐ Salary ☐ Vacation Time ☐ Sick Days ☐ Other: _____ Monthly Amount: $ _____

3. While on disability leave, did you have a second job? ☐ Yes ☐ No

   If Yes, specify: _____

4. Are you currently receiving benefits or planning to request benefits from one of the following:

| Program | No | If Yes | | | | | | Do you intend to contest this decision? | |
|---|---|---|---|---|---|---|---|---|---|
| | | At School | Approved | Reference Number | Amount | Payment Frequency | Denied | Yes | No |
| Commission des normes en santé et sécurité au travail (CNESST) or similar organization | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |
| Société de l'assurance automobile du Québec (SAAQ) or similar organization | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |
| Employment and Social Development Canada (ESDC) | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |
| Régie des rentes du Québec (RRQ) disability pension | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |
| Canada Pension Plan (CPP) disability benefit | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ | | $ _____ | | ☐ | ☐ | ☐ |

Note: Please include a copy of all documents received from these organizations, including benefit payment notices.

## Professional Activity Information

1. What is your normal work schedule? _____

   Average number of hours worked per week? _____

2. Please split your work time according to the following tasks:

| Task | % of Weekly Hours | Hours |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

3. Answer Yes or No to the questions below pertaining to the year before your disability leave. If Yes, please explain.

   a) Did your responsibilities change? ☐ Yes ☐ No

   Explain: _____

   b) Did your tasks change? ☐ Yes ☐ No

   Explain: _____

## Current Situation

When were you declared unfit to work? Date Y Y Y Y M M D D Is your disability leave: ☐ Total ☐ Partial

1. Is your disability the result of an accident? ☐ Yes ☐ No
   Location: ☐ At home ☐ At work ☐ Elsewhere, specify: _____
   Date: Y Y Y Y M M D D
   Circumstances: _____
   _____
   If it was a car accident, were you the: ☐ Driver ☐ Passenger
   If you are not a Quebec resident, please provide a police report.
2. Is the disability leave work-related? ☐ No ☐ Yes
   Specify: _____
   _____
3. If you are back at work, on what date did you return: Y Y Y Y M M D D
4. If you are not back at work, what is your likely or expected return-to-work date? Y Y Y Y M M D D
5. Have you been on disability in the last 12 months? ☐ Yes ☐ No
   If Yes, can you tell us if your current disability leave is due to the:
   ☐ Same condition ☐ Different condition
   Please indicate your return-to-work schedule: _____
   _____
6. Are you in the hospital? ☐ No ☐ Yes
7. Describe all symptoms, including their severity and frequency: _____
   _____
8. Explain why your health condition prevents you from working:
   _____
   _____
9. Describe the tasks that you are no longer able to perform: _____
   _____
10. Are other work-related factors affecting your return to work?
    ☐ No ☐ Yes, specify: _____
    _____
11. Briefly describe your daily activities since going on disability leave: _____
    _____

## Attending Physician and Medical History

1. Name of attending physician: _____
   Date of first visit: Y Y Y Y M M D D
   Address: _____
2. Were you hospitalized for this condition? ☐ No ☐ Yes Date Y Y Y Y M M D D
   Hospital: _____
3. When did your symptoms appear? _____
4. When did you first consult a doctor? Y Y Y Y M M D D
5. Have you ever had a similar illness or injury in the past? ☐ No ☐ Yes Date Y Y Y Y M M D D
6. Are you able to make a progressive return to work? ☐ No ☐ Yes
7. Did your attending physician prescribe medication? ☐ No ☐ Yes
   If Yes, are you taking it regularly? ☐ No ☐ Yes

8. In the two years prior to your disability leave, did you consult a doctor or healthcare professional or were you hospitalized for problems related to the condition that is causing you to be on disability leave at this time?* ☐ No ☐ Yes

* Fill out only if you have been insured for less than two years.

| Illness | Date of Consultation or Treatment | Prescribed Treatment/ Medication/Other | Name and Address of Physician |
|---|---|---|---|
| | Y Y Y Y M M D D | | |
| | Y Y Y Y M M D D | | |
| | Y Y Y Y M M D D | | |
| | Y Y Y Y M M D D | | |

## Insured Person's Confirmation and Authorization

I CONFIRM that, to the best of my knowledge, all declarations pertaining to this form and during all in-person or telephone interviews are true and accurate. IT IS UNDERSTOOD AND AGREED that these declarations are the basis for all benefits paid as a result of this claim.

**I HEREBY AUTHORIZE**

(i) all healthcare service providers or professionals, all healthcare organizations or institutions, the Medical Information Bureau, all insurance or reinsurance companies, all credit investigation or rating agencies, all workplace health and safety commissions as well as the plan administrator to contact or request information or files (including the physician's notes) and all other personal or medical information as well as all information about me that is required to evaluate my disability benefits claim from SSQ, Life Insurance Company Inc., and any other person and all public or private organizations or establishments, their employees, their reinsurers or the agencies acting on their behalf;

(ii) SSQ, Life Insurance Company Inc. to share with the plan administrator information required to evaluate my disability benefits claim or assess my rehabilitation options and plan my return to work; and

(iii) SSQ, Life Insurance Company Inc. to forward my file to one or several doctors of their choosing for a second medical opinion.

A photocopy of this section is considered as valid as the original.

This confirmation and authorization section applies only to this disability benefits claim.

Insured Person's Signature

Y Y Y Y M M D D
Date

Address

City

Province

Postal Code

Home Phone

Work Phone

Ext.