Assumption Life
Group Insurance

DISABILITY CLAIM

(INITIAL REQUEST)

Assumption Life
Group Insurance

Disability Claim (Initial Request) Instructions

Policyholder (employer or plan administrator)

1. Please complete the "Policyholder's Statement" and ensure that you answer all questions to avoid file review delays.

2. For long-term disability benefits or waiver of premium benefits (without short-term disability coverage requests), Assumption Life must receive the duly completed form signed by all parties **6 to 8 weeks before the waiting period expires**.

Employee

1. Please complete the "Employee's Statement" and ensure that you answer each question, to avoid file review delays. Do not forget to sign the "Employee's Authorization & Acknowledgement" in section 7.

2. Please ensure that your attending physician completes the *Initial Disability Insurance Medical Statement*. You must also complete the "Section 1 - Patient Information and Consent" AND sign the authorization at the top of the *Initial Disability Insurance Medical Statement*.

3. Please enclose a photocopy of the benefit statement from any 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 any government plan mentioned in number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of the file.

Please Note:

a) It is your responsibility to pay any fees that may be incurred to have this form completed by your attending physician.

b) Please return the entire document to the following address and include all pages. **Please do not use staples.**

ASSUMPTION LIFE, c/o Group Insurance
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
Telephone: 1-855-244-7011 Fax: 1-855-401-9068

c) Alternatively, you can **scan** and **e-mail** the forms to: lifedisability@assumption.ca

Attending Physician

1. Please complete the *Initial Disability Insurance Medical Statement* ensuring that you answer all questions to avoid file review delays.

2. Please provide any other documentation pertinent to the evaluation of this claim (test results of various examinations carried out and specialist consultation reports).

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Assumption Life
Group Insurance

RESET

Disability Claim (Initial Request) Policyholder's Statement

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

To speed processing, please answer all questions. Please Print.

Name of Policyholder _____ Authorized Person's Name _____

Address _____ City _____ Province _____ Postal Code _____

Telephone _____ Email _____ Fax _____

Section 1 Employee Information

Employee's First Name _____ Employee's Last Name _____ Policy _____ Division _____ Certificate _____

1. Occupation (Please attach a copy of the job description and complete the information below)

Current position: _____ Start Date: (DD/MM/YYYY) ____/____/ _____

Type of position: ☐ Regular fulltime position ☐ Regular part-time position ☐ Term employee ☐ Seasonal employee

Is the employee: ☐ Hourly ☐ Salaried ☐ Commissioned (Please provide T4 for the last 3 years)

2. Physical Work Environment

A) What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties: _____ ____ % Duties: _____ ____ %
Duties: _____ ____ % Duties: _____ ____ %

For questions B, D and E, FREQUENCY is defined as follows:
Occasionally : 0%-15% of the time Frequently : 16%-50% of the time Always : 51%–100% of the time

B) Work environment – Does the employee's job require work in any of the following conditions?

Frequency	O	F	A	Frequency	O	F	A	Frequency	O	F	A
☐ Outside	☐	☐	☐	☐ Above or below ground level	☐	☐	☐	☐ In extremes of cold or heat	☐	☐	☐
☐ Toxic fumes	☐	☐	☐	☐ In a damp or humid environment	☐	☐	☐	☐ Handling of chemicals	☐	☐	☐

C) Does the job involve other hazards? ☐ Yes ☐ No
If yes, please list: _____

D) Check the items below that relate to the employee's job:

Frequency	O	F	A	Frequency	O	F	A	Frequency	O	F	A
☐ Standing	☐	☐	☐	☐ Bending over	☐	☐	☐	☐ Crouching	☐	☐	☐
☐ Walking	☐	☐	☐	☐ Keeping one's balance	☐	☐	☐	☐ Climbing	☐	☐	☐
☐ Sitting	☐	☐	☐	☐ Extending/reaching above head	☐	☐	☐	☐ Stairs (number_____)	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐ Crawling	☐	☐	☐	☐ Ladders (height_____)	☐	☐	☐

E) Describe activity and specify frequency and weight:

	Frequency: O	F	A	Weight:	
☐ Pushing: _____	☐	☐	☐	_____	☐ lb ☐ kg
☐ Pulling: _____	☐	☐	☐	_____	☐ lb ☐ kg
☐ Lifting/carrying: _____	☐	☐	☐	_____	☐ lb ☐ kg

F) Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment: _____ Times per day: _____
Type of equipment: _____ Times per day: _____

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Employee's First Name | Employee's Last Name | Policy | Division | Certificate

Section 1 Employee Information (continued)

G) Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? ☐ Yes ☐ No If yes, please specify: _____

H) Does the employee's job require dexterity? ☐ Yes ☐ No If yes, please specify: _____

I) Are there any other potential work-related factors which may influence this employee's return to work? ☐ Yes ☐ No
If yes, please specify: _____

3. Cognitive / Non-Physical Work Environment

A) Does the employee have to answer complaints? ☐ Yes ☐ No

B) Is the employee primarily evaluated on production? ☐ Yes ☐ No

C) Does the employee work closely with coworkers? ☐ Yes ☐ No

D) Is the employee responsible for the performance objectives / decision making within his/her particular department? ☐ Yes ☐ No

E) Number of people the employee supervises: _____

F) What percentage (%) of the employee's time is spent in the following activities?
Talking: _____(%) Writing: _____(%) Supervising other people: _____(%)

G) Please list any other relevant aspects of the job that may be considered stressful: _____

4. Job Tasks and Performance

A) When did the employee's health problem first appear to affect his/her work? (DD/MM/YYYY) ____/____/_____

B) In what ways did on-the-job performance change as a result of this health problem? _____

C) Were any changes made in the employee's job duties as a result of this health problem? ☐ Yes ☐ No
If yes, please specify: _____

D) If the employee could return to part-time or less demanding work, would such work be available? ☐ Yes ☐ No
If no, please explain: _____

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Employee's First Name	Employee's Last Name	Policy	Division	Certificate

Section 1 – Employee Information (continued)

5. Coverage and Employment

A) Was the coverage in effect on the first day of the current period of absence from work? ☐ Yes ☐ No

If yes, what is the effective date of the employee's disability insurance coverage? (DD/MM/YYYY)____/____/_____
If no, please explain: _____

B) Effective date of coverage with previous insurer, if disability began less than 12 months from the effective date of current coverage :
Date: (DD/MM/YYYY)____/____/_____

C) Date hired: (DD/MM/YYYY)____/____/_____ Start date of current position: (DD/MM/YYYY)____/____/_____

Last day at work: (DD/MM/YYYY)____/____/_____ Number of hours worked: _____

D) Date of return to work (if applicable): (DD/MM/YYYY)____/____/_____ ☐ Full time ☐ Part time ☐ Regular Position

E) Primary reason for current absence from the workplace:

☐ Occupational illness ☐ Motor vehicle accident ☐ Pregnancy related condition
☐ Illness ☐ Accident outside of work ☐ Accident at work

F) On the date the current period of absence from work began, was the employee:

☐ On **paid** leave ☐ Laid off ☐ On disciplinary suspension **without** pay ☐ Other: _____
☐ On **unpaid** leave ☐ On vacation ☐ On disciplinary suspension **with** pay

Section 2 – Employee's Work Schedule and Earnings Information

1. Indicate the hours of work in a normal week: _____ For an irregular schedule, indicate the daily schedule.
Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____

2. Employee's gross annual salary when last actively at work: $_____
Salary effective date: (DD/MM/YYYY)____/____/_____

3. Tax credits: Federal (TD1):_____ Provincial (TPD1): _____

4. Has or will the employee receive other amounts apart from the disability insurance benefits during the current period of absence from work? ☐ Yes ☐ No For the period of_____ to _____

Specify: ☐ Vacation ☐ Maternity leave ☐ Employment insurance (HRSDC) ☐ Sick leave ☐ Statutory holidays

5. Has the employee applied or will he/she be applying to any of the organizations below? ☐ Yes ☐ No

If so, please specify: ☐ Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization
☐ Société de l'assurance automobile du Québec (SAAQ) or other similar organization
☐ Human Resources and Social Development Canada (HRSDC)
Canada Pension Plan (CPP) - ☐ Disability pension / ☐ Retirement pension
Régie des rentes du Québec (RRQ) - ☐ Disability pension / ☐ Retirement pension

6. If the employee is already receiving benefits from one of the sources above, please specify the amount/frequency: $_____/_____
Attach a copy of the letter of acceptance.

7. If the employee is pregnant, has an application for a preventative withdrawal been submitted to the CSST (Québec only), or will it be?

☐ Yes ☐ No

8. Has the employee returned to work? ☐ Yes ☐ No If yes, on what date? (DD/MM/YYYY)____/____/_____

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Group Insurance

Employee's First Name	Employee's Last Name	Policy	Division	Certificate

Section 2 Employee s Work Schedule and Earnings Information

9. Is this person still in your employ? ☐ Yes ☐ No
   If no, specify termination date. (DD/MM/YYYY)____/____/ _____

   Reason: _____

10. Was this person given a record of employment? ☐ Yes ☐ No

11. Please provide any additional information that you believe should be considered in assessing this employee's claim.

First and last name of the authorized person (in block letters)

Position

Signature

Date (DD/MM/YYYY)

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Disability Claim (Initial Request) Employee's Statement

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

To ensure prompt processing, please answer all questions and obtain all required signatures.

First Name _____ Last Name _____ Policy _____ Division _____ Certificate _____

Social Insurance Number _____ Language: ☐ French ☐ English ___/___/_____ Date of birth (DD/MM/YYYY) Gender: ☐ F ☐ M

Address _____ City _____ Province _____ Postal Code _____

Fax _____ E-mail _____

Telephone - Home _____ Telephone – Work _____ Telephone - Cell _____

Section 1 General Information

Training: _____ Spoken language: ☐ French ☐ English

Level of education: _____ Written language: ☐ French ☐ English

Work experience: _____

If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy Number	Certificate Number	Date Benefits Commenced (DD/MM/YYYY)	Benefit Period (DD/MM/YYYY)	Benefit Amount	Weekly or Monthly
			___/___/_____	___/___/_____to_____/___/_____	$	☐ W ☐ M
			___/___/_____	___/___/_____to_____/___/_____	$	☐ W ☐ M
			___/___/_____	___/___/_____to_____/___/_____	$	☐ W ☐ M

Section 2 Reason for the Claim

1. If the sick leave was the result of an accident, indicate:

A) Place of the accident: ☐ Home ☐ Work ☐ Elsewhere (specify) _____

B) Date of the accident: (DD/MM/YYYY)___/___/_____

C) Circumstances: _____

D) If a car accident, specify whether you were: ☐ the driver ☐ a passenger If not a Quebec resident, please submit the police report.

2. Is your current absence from the workplace due to work-related issues? ☐ Yes ☐ No Please elaborate: _____

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Name of employee: _____

Section 3 Occupation

Date hired: (DD/MM/YYYY)____/____/_____ When did you become unable to work? (DD/MM/YYYY)____/____/ _____

1. Explain how your condition is preventing you from working. _____

2. Describe the duties of your job that you can no longer perform. _____

3. When you stopped working, were you working elsewhere (second job)? ☐ Yes ☐ No If yes, specify: _____

Section 4 Current Situation

1. A) Are you confined to your home? ☐ Yes ☐ No
   B) Are you confined to your bed? ☐ Yes ☐ No
   C) Are you hospitalized? ☐ Yes ☐ No

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

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

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Group Insurance

Name of employee: _____

Section 5 Income from Other Sources

1. Are you currently performing any work, even part-time, for which you receive any form of compensation? ☐ Yes ☐ No

2. Please indicate your entitlement to Disability Benefits, Income Replacement or waiver of payments from these sources as a result of your current health problem.

Source	Applied	Intend to Apply	Date of Claim Submission (DD/MM/YYYY)	Benefit Commencement Date (DD/MM/YYYY)	Amount and Frequency of Payment
Canada/Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Retirement Income/ Social Security	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
WSIB/WCB/CSST	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Employment Insurance Canada	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Car Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
War Veteran's Disability Pension	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Group Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Individual Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	
Other (specify): _____	☐ Yes ☐ No	☐ Yes ☐ No	___/___/_____	___/___/_____	

PROVIDE A COPY OF CORRESPONDENCE CONFIRMING BENEFIT PAYMENT.

Section 6 Physicians and History

1. Name of your attending physician: _____ Date of initial visit: (DD/MM/YYYY) ____/____/_____
   Address: _____
   Telephone: _____ Fax : _____

2. Have you been hospitalized for this medical condition? ☐ Yes ☐ No Date: (DD/MM/YYYY) ____/____/_____
   Name of Hospital: _____ Location: _____

3. When did your symptoms begin? _____
   _____
   _____

4. When did you first consult a physician for this medical condition? _____

5. Have you ever had a similar illness or injury before? ☐ Yes ☐ No Date: (DD/MM/YYYY) ____/____/_____

6. Would you be able to return to work gradually? ☐ Yes ☐ No

7. Has your attending physician prescribed medication? ☐ Yes ☐ No If yes, are you taking it regularly? ☐ Yes ☐ No

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Name of employee: _____

Section 6 Physicians and History (continued)

8. List all the physicians who have treated you in the last two years.

Illness	Consultation or treatment date	Treatment prescribed, medication, other	Name of Physician	Address of physician
	___ /___/ _____			
	___ /___/ _____			
	___ /___/ _____			
	___ /___/ _____			
	___ /___/ _____			

Section 7 Employee s Authorization & Acknowledgement

I certify that the information given on this form is true, correct and complete.

For purpose of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize Assumption Life, its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), workers compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of myself, to give to Assumption Life full particulars of such information, including, without limiting the generality of the foregoing, any information regarding my lifestyle, health, prior medical history and benefits.

I transfer and assign to Assumption Life, and agree to pay and refund to Assumption Life those disabilities and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Workers' Compensation, and other insurance policies.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or any professional organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating such fraud or abuse.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

_____
Name (in block letters)

_____ _____
Employee's Signature Date (DD/MM/YYYY)

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The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1 — Patient Information and Consent
TO BE COMPLETED BY THE PATIENT

Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1.		
2.		
3.		
4.		
5.		

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

_____ _____
Patient Signature Date of Consent (dd/mm/yyyy)

Section 2 — Medical Statement
TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify)_____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

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Is this condition due to:

Occupational Illness Yes ☐ No ☐

Occupational Injury Yes ☐ No ☐

Motor vehicle accident Yes ☐ No ☐

Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requester: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition:
(dd/mm/yyyy) _____

First date of work absence due to condition:
(dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1)**

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: Treatment Provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

- **If your patient has returned to work, or if the duration of their disability will be less than 4 wFFLT, QMFBTF TUPQ IFSF and sign the end of the form.**
- **For disabilities expected to be greater than 4 weeks, please complete all pages.**

Investigations

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**
- **clinical notes**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

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Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy)_____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate:_____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address

Signature

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Direct Deposit Form

General Information	First name:_____ Last name: _____ Address: _____ _____ Telephone: _____ Policy:_____ Division:_____ Certificate: _____
Banking Information	**Please attach a blank cheque marked "VOID", or an official document from your financial institution confirming your account number, branch number and financial institution number.**
Authorization	I hereby authorize and request Assumption Life to credit payments due to me to my account with the financial institution indicated on the attached void cheque. This authorization may be cancelled at any time upon written notice by me.
Date & Signature	_____ _____ Authorized Signature Date (DD/MM/YYYY)

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