La Capitale

Application for short and/or long term Disability Insurance Benefits

Initial Application

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com

CONTRACT NO.	EMPLOYER NO.	IDENTIFICATION NO.
1	2	3

Insured's Declaration (Complete in block letters)

4 LAST NAME		5 FIRST NAME	
6 ADDRESS NO. STREET APT.		TOWN/CITY	POSTAL CODE
7 HOME TEL. ( ) -	8 WORK TEL. ( ) -	9 GENDER ☐ M ☐ F	10 DATE OF BIRTH Year Month Day

11 INCOME TAX STATUS
Single ☐ | Single-parent ☐ | Married or de facto spouse ☐

DEPENDANTS
Spouse: ☐ no ☐ yes | Children: ☐ no ☐ yes → Number: ____

12 Since you stopped working, have you carried out another occupation? ☐ No ☐ Yes → Start date: Year Month Day

If yes, specify nature of activities: _____

13 Was your disability caused by an accident? ☐ No ☐ Yes → Describe circumstances, date and place.

14 Have you applied for or are you receiving any disability, wage loss or retirement benefits from a program or plan mentioned below?

	NO	IF YES			IF DECLINED	
		Pending	Approved	Declined	Do you intend to contest the decision? Yes	No
PROGRAM Employment Insurance (EI/HRDC) — If approved, start date of benefits: Year Month Day	☐	☐	☐	☐	☐	☐
Workers' Compensation or similar plan / *Commission de la santé et de la sécurité du travail* (WSIB/CSST)	☐	☐	☐	☐	☐	☐
Crime Victims Compensation Act (CVCA)	☐	☐	☐	☐	☐	☐
Automobile Insurance Benefits / *Société de l'assurance automobile du Québec* (AB/SAAQ)	☐	☐	☐	☐	☐	☐
PLAN Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)	☐	☐	☐	☐	☐	☐
Commission administrative de régimes de retraite et d'assurances (CARRA)	☐	☐	☐	☐	☐	☐
Retirement / Pension Plan	☐	☐	☐	☐	☐	☐
Any other disability benefits:	☐	☐	☐	☐	☐	☐

NOTE: PLEASE ENCLOSE A COPY OF ALL DOCUMENTS RECEIVED FROM THESE ORGANIZATIONS, INCLUDING ANY NOTICE OF PAYMENT OF BENEFITS

15 Declaration

I hereby certify that the information provided below is true and complete. I hereby authorize the group plan administrator and La Capitale Civil Service Insurer Inc. to use my social insurance number for administration and/or identification purposes.

16 Authorization

I hereby authorize any physician, any other professional and participating party in the health care and rehabilitation sectors as well as any public or private health or social services institution, any insurance company, as well as any insurer, any public or private institution, any information officer who has received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person who has files or personal information, especially medical information to provide to La Capitale Civil Service Insurer Inc. or to its agents, subsidiaries, affiliates, third party administrators and reinsurers, all information that he, she or it has, for the following purposes: to investigate and confirm the accuracy of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

I also authorize La Capitale Civil Service Insurer Inc. to disclose this information to the persons indicated above whenever necessary, within the framework of their activities and the processing of my file. In the event of death, I formally authorize the policyholder, employer, beneficiary, heir or liquidator of my succession, to provide to La Capitale Civil Service Insurer Inc. or to its mandataries when required, all information or authorizations that make possible the processing of my file.

This authorization is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy or electronic copy of this authorization shall be as valid as the original.

_____ Signature of Insured

Year Month Day
Date

Important

The following sections must be completed and signed:

By the insured
- Insured's Declaration
- Upper section of the declaration completed by the attending physician

By the employer
- Employer's Declaration

By the attending physician
- Attending Physician's Declaration

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Initial Application

Employer's or Policyholder's Declaration

1 Name and address of employer: _____ Postal Code

2 Contract No.: _____ Employer No.: _____

Tel.: ( ) - Ext.: _____

3 Employee's last name: _____ 4 Employee's first name: _____

5 Employee's occupation: _____

6 Employee's main duties: _____

7 Employment start date: Year Month Day

8 Social Insurance Number (If taxable Benefit):

9 Employee's Identification No.:

10 Monthly salary at the start of disability: Gross: $ _____

FEDERAL PROVINCIAL

11 Personal tax exemptions: $ _____ $ _____

12 Full time ☐ Part time ☐ % of part time worked _____ On call ☐ Other ☐ (Specify): _____

13 Indicate the working days in an ordinary week: M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S ☐ Schedule: From _____ Time to _____ Time

14 Number of hours worked in an ordinary week: _____

15 Last day at work: Year Month Day

16 Number of hours worked that day: _____

17 Date of first day of absence from work: Year Month Day

18 Has the employee returned to work? No ☐ Yes ☐ Date: Year Month Day

19 Is the disability due to: A workplace accident? ☐ An occupational disease? ☐

20 If the employee is currently pregnant, has an application been made or will one be made to the CSST under the *Act respecting Occupational health and safety?*

No ☐ Yes ☐

21 Does the disability coincide with:

A dismissal? No ☐ Yes ☐ → Date: Year Month Day

A lay off? No ☐ Yes ☐ → from Year Month Day to Year Month Day Date notice given: Year Month Day

The elimination of a workstation? No ☐ Yes ☐ → Date: Year Month Day

A leave without pay? No ☐ Yes ☐ → from Year Month Day to Year Month Day

Other, please specify: _____ from Year Month Day to Year Month Day

22 During the period of disability, have you paid any amounts to this employee? No ☐ Yes ☐

	Nature	Period	Amount
If yes, please specifiy the nature, period and amount: (e.g. vacation, sick pay, employment insurance, etc.)			

23 If the employee is able to perform work adapted to his or her condition, would it to be possible to reassign him or her to another position in your organization? No ☐ Yes ☐

If yes, please specify: _____

24 Is there any other information relevant to this application that we should be aware of? No ☐ Yes ☐

If yes, please specify: _____

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

_____ Signature of Authorized Representative

Year Month Day Date

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PHYSICAL ILLNESSES

Section to be completed by the Insured

Note: For psychological illnesses, complete the reverse of this form.

1. Last Name: _____ 2. First Name: _____
3. Contract No.: _____ 4. Social Insurance No.: _____
5. Date of Birth: Year ____ Month ____ Day ____

Attending Physician's Declaration (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Primary: _____

1.2 Secondary: _____

1.3 Complications: _____

1.4 For the illnesses or related symptoms diagnosed, has the patient previously:

a) received medical treatment ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify periods: _____

1.5 Please specify whether the incapacity is related to: An accident ☐ An illness ☐ An occupational accident ☐ An automobile accident ☐

Date of the event: Year ____ Month ____ Day ____

Pregnancy No ☐ Yes ☐

A preventive withdrawal from work No ☐ Yes ☐ Expected date of delivery: Year ____ Month ____ Day ____

1.6 Describe the functional limitations preventing the patient from carrying out his or her professional duties or usual activities.

At the start of disability Year ____ Month ____ Day ____ Currently

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 Specify if the patient has undergone or will undergo:

a) Examinations or tests No ☐ Yes ☐ Specify: _____

b) An operation No ☐ Yes ☐ Day surgery ☐ Type _____

Surgical procedure: ↳ Date: Year ____ Month ____ Day ____

c) Other treatments: No ☐ Yes ☐ Specify: _____

d) Hospitalization: from _____ to _____ Name of hospital: _____

e) A short stay under observation: No ☐ Yes ☐ (No. of hours): _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Year ____ Month ____ Day ____ Next consultation: Year ____ Month ____ Day ____

3.2 Dates of other consultations: _____ Follow-up frequency: _____

3.3 Referral to another physician: No ☐ Yes ☐ Name of physician: _____

Specialty: _____

3.4 Approximate duration of disability: No. of days _____ No. of weeks _____ Indefinite ☐ or Date of return to work Year ____ Month ____ Day ____

3.5 How long before the patient is likely to be able to return to work? No. of days _____ No. of weeks _____

Part time ☐ Full time ☐ Gradual return ☐ Specify: _____

4. Contract-specific questions

5. Identification of physician

5.1 Last name, first name: _____ Tel.: _____

5.2 License No.: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Year ____ Month ____ Day ____

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PSYCHOLOGICAL ILLNESSES

Section to be completed by the Insured

Note: For physical illnesses, complete the reverse of this form

1. Last Name: _____ 2. First Name: _____
3. Contract No.: _____ 4. Social Insurance No.: _____
5. Date of Birth: _____ (Year / Month / Day)

Attending Physician's Declaration (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Primary: _____

1.2 Secondary: _____

1.3 Current symptoms: _____

1.4 Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe ☐ With psychotic elements ☐

1.5 Describe the functional limitations preventing the patient from carrying out his or her professional duties or usual activities.

At the start of disability	Currently

1.6 Specify whether the patient's absence from work is due to problems related to:

☐ Marital/family life ☐ Loss of employment or layoff ☐ Occupational problems
☐ Personal or interpersonal problems ☐ Alcohol or drug abuse and/or gambling problems
☐ Other, specify: _____

1.7 For the illnesses or related symptoms diagnosed, has the patient previously:

a) received medical treatment ☐ c) taken drugs ☐ e) undergone examinations ☐
b) consulted another physician ☐ d) been hospitalized ☐

Please specify dates of any previous episodes: _____

2. Treatment

2.1 Drugs – name – dosage:

2.2 Specify whether the patient is consulting:

A psychiatrist	No ☐	Yes ☐	A social worker	No ☐	Yes ☐
A psychologist	No ☐	Yes ☐	Another health care provider	No ☐	Yes ☐

If yes, name of service provider: _____

2.3 Hospitalization: from _____ to _____ Name of hospital: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: (Year / Month / Day) Next consultation: (Year / Month / Day)

3.2 Dates of other consultations: _____

3.3 Follow-up frequency: _____

3.4 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician: _____

3.5 Approximate duration of disability: No. of days _____ No. of weeks _____ Indefinite ☐ or Date of return to work (Year / Month / Day)

3.6 How long before the patient is likely to be able to return to work? No. of days _____ No. of weeks _____

Part time ☐ Full time ☐ Gradual return ☐ Specify: _____

4. Contract-specific questions

5. Identification of physician

5.1 Last name, first name: _____ Tel.: _____

5.2 License No.: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: (Year / Month / Day)

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.