



La Capitale Insurance and Financial Services Inc.

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 prest.inv@lacapitale.com

GROUP NO.		EMPLOYER NO.		IDENTIFICATION NO.	
1		2		3	
4 LAST NAME			5 FIRST NAME		
6 ADDRESS NO. STREET APT.		TOWN/CITY		POSTAL CODE	
7 HOME TEL. () -	8 WORK TEL. () -	9 GENDER <input type="checkbox"/> M <input type="checkbox"/> 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?	PROGRAM	If approved, start date of benefits: Year Month Day	NO			IF YES			IF DECLINED	
			NO	Pending	Approved	Declined	Do you intend to contest the decision? Yes No			
	Employment Insurance (EI/HRDC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Workers' Compensation or similar plan / Commission de la santé et de la sécurité du travail (WSIB/CSST)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Crime Victims Compensation Act (CVCA)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Automobile Insurance Benefits / Société de l'assurance automobile du Québec (AB/SAAQ)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PLAN Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Commission administrative de régimes de retraite et d'assurances (CARRA)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Retirement / Pension Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Any other disability benefits:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 Insurance and Financial Services 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 Insurance and Financial Services 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 Insurance and Financial Services 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 Insurance and Financial Services 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.

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

Signature of Insured

Date

Employer's Declaration

1 Name and address of employer: _____

 _____ Postal Code _____
 Tel.: () _____ - _____ Ext.: _____

2 Group No.: _____
 Employer No.: _____

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 Employee's Identification No.: _____

9 Monthly salary at the start of disability: Gross: \$ _____
 FEDERAL PROVINCIAL

10 Personal tax exemptions: \$ _____ \$ _____

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

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

13 Number of hours worked in an ordinary week: _____

14 Last day at work: _____ **15** Number of hours worked that day: _____
Year Month Day

16 Date of first day of absence from work: _____
Year Month Day

17 Has the employee returned to work? No Yes Date: _____
Year Month Day

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

19 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

20 Does the disability coincide with:

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

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

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

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

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

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

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

22 If the employee is able to perform work adapted to his or her condition, would it be possible to reassign him or her to another position in your organization? No Yes
 If yes, please specify: _____

23 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

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.

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: _____

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 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: _____
 1.6 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.