La Capitale

Application for extension
short and/or long term
Disability Insurance

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

This form must be completed by the insured or, if unable to do so personally, by another person on the insured's behalf. La Capitale Civil Service Insurer Inc. (hereinafter La Capitale) reserves the right to require any additional information it deems necessary. The company assumes no liability for any expenses incurred in providing the proof required for claims.

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 Are you still totally disabled?

☐ No – disability end date: Year Month Day

☐ Yes – without interruption since: Year Month Day

12 Have you worked part time since the beginning of your disability?

☐ No ☐ Yes How many days or hours per week? _____

13 a) Return to full-time work: Y M D

b) Gradual return to work: Year Month Day

14 Since the last report, have you consulted a health professional, received treatments or undergone any examinations? ☐ No ☐ Yes

If so, please provide details below.

Hospitals and physicians consulted during your current disability:

Name and address of hospital or physician	Date	Treatments/operations

15 What medication are you currently taking? _____

16 Have you applied or do you plan to apply for any disability, wage loss or retirement benefits with a government body and/or another insurance company? ☐ No ☐ Yes

If so, which organization? _____ Date of application: Year Month Day ☐ Approved ☐ Declined ☐ Under assessment

Other: Name of insurance company _____ File No. _____ ☐ Approved ☐ Declined ☐ Under assessment

17 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.

18 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

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

Supplementary Report

Employer's or Policyholder's declaration (Complete in block letters)

1 Name and address of employer: _____ 2 Contract No.: _____

(Continue to next question if no change since last declaration) _____ Employer No.: _____

_____ Postal Code

Tel.: ( ) - _____ Ext.: _____

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

5 Employee's Identification No.: _____

6 Is the employee still employed by you? Yes ☐ No ☐

If not, please specify reason:

Dismissal No ☐ Yes ☐ → Date: Year Month Day

Layoff No ☐ Yes ☐ → From Year Month Day To Year Month Day Date notice given: Year Month Day

Position abolished No ☐ Yes ☐ → Date: Year Month Day

Leave without pay No ☐ Yes ☐ → From Year Month Day To Year Month Day

Other, please specify: _____ From Year Month Day To Year Month Day

7 Has the employee returned to work? Yes ☐ No ☐

	Date	Occupation
If so, please specify the date and occupation:		

8 Since your last declaration, have you paid any amounts to this employee? No ☐ Yes ☐

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

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

If so, please specify: _____

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

_____ Signature of Authorized Representative

Year Month Day Date

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

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Supplementary Report

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 Objective elements of physical examination and investigation (**attach copy** of recent results, X-rays, ECG, or other tests or examinations):

Weight: _____ lb ☐ kg ☐ Height: _____ ft/in ☐ _____ m/cm ☐ Most recent blood pressure: _____

1.4 Degree of severity of symptoms (M=mild, Md=moderate, S=severe)

	M	Md	S		M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 Additional treatments (specify type and frequency): _____

2.3 Surgery (date, nature and procedure): _____

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

2.5 Consultation with a specialist: No ☐ Yes ☐ → **Attach copy of report**

3. Medical follow-up and prognosis

3.1 Date of last consultation: Year ____ Month ____ Day ____ Next consultation: Year ____ Month ____ Day ____

3.2 Tests and examinations to come, specify: _____

3.3 Frequency of follow-up: _____

3.4 Referral to a specialist: No ☐ Yes ☐ Name of physician: _____

3.5 Scheduled date of consultation with a specialist: Year ____ Month ____ Day ____ Specialty: _____

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

At the start of disability	Currently

3.7 Evolution: Progressive ☐ Stable ☐ Regressive ☐

3.8 If you anticipate that this absence from work will extend beyond the usual period for such a diagnosis, please explain the factors justifying your prognosis.

3.9 Patient's cooperation in treatment: Excellent ☐ Average ☐ Poor ☐

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

3.11 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.

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

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Supplementary Report

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 Please describe signs and symptoms and indicate the frequency and degree of severity of each: (M = Mild Md = Moderate S = Severe)

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

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

At the start of disability	Currently

2. Treatment

2.1 Drugs – name – dosage: _____

2.2

Specify whether your patient is consulting a:			Since when?	Treatment provided by/in:			Specify:
Psychiatrist	No ☐	Yes ☐		Treatment centre	No ☐	Yes ☐	
Psychologist	No ☐	Yes ☐		CLSC	No ☐	Yes ☐	
Social worker	No ☐	Yes ☐		Day hospital	No ☐	Yes ☐	
Other health professional	No ☐	Yes ☐		Group therapy	No ☐	Yes ☐	
				Individual therapy	No ☐	Yes ☐	

AXIS II) Associated personality disorders? No ☐ Yes ☐ Specify: _____
Associated drug addiction, alcoholism or gambling problems? No ☐ Yes ☐ Specify: _____

AXIS III) Associated illness: – Diagnosis: _____
– Drugs prescribed: _____

AXIS IV) Associated psychosocial stress factors (in the last 12 months):
☐ Personal or interpersonal problems ☐ Loss of employment or layoff ☐ Occupational problems
☐ Marital or family problems ☐ Alcohol or drug abuse and/or gambling problems
☐ Other, specify: _____

AXIS V) General functioning scale (according to DSM-IV GFS scale (0 to 100) 100 = perfect condition) → At start of treatment: _____ Currently: _____

3. Follow-up and prognosis

3.1 Date of last consultation: Year ____ Month ____ Day ____ Next consultation: Year ____ Month ____ Day ____

3.2 Follow-up frequency: _____

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

3.4 Patient's cooperation in treatment: Excellent ☐ Average ☐ Poor ☐

3.5 If you anticipate that this absence from work will extend beyond the usual period for such a diagnosis, please explain the factors justifying your prognosis.

3.6 Do you consider that the patient's condition has improved in an optimal way? No ☐ Yes ☐

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

3.8 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.