



# Application for extension short and/or long term Disability Insurance

**La Capitale Insurance and Financial Services Inc.**  
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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 Insurance and Financial Services 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.

Insured's Declaration (Complete in block letters)		GROUP NO. <b>1</b>	EMPLOYER NO. <b>2</b>	IDENTIFICATION NO. <b>3</b>
<b>4</b> LAST NAME	<b>5</b> FIRST NAME			
<b>6</b> ADDRESS NO. STREET APT.	TOWN/CITY		POSTAL CODE	
<b>7</b> HOME TEL. ( ) -	<b>8</b> WORK TEL. ( ) -	<b>9</b> GENDER <input type="checkbox"/> M <input type="checkbox"/> F	<b>10</b> DATE OF BIRTH Year Month Day	
<b>11</b> NAME OF EMPLOYER:	<b>12</b> PROFESSION/OCCUPATION:			
<b>13</b> Start of disability: Year Month Day	<b>15</b> Are you still totally disabled? <input type="checkbox"/> No – disability end date: Year Month Day <input type="checkbox"/> Yes – without interruption since: Year Month Day			
<b>14</b> Last day worked: Year Month Day	<b>16</b> Have you worked part time since the beginning of your disability? <input type="checkbox"/> No <input type="checkbox"/> Yes How many days or hours per week? _____			
<b>17</b> a) Return to full-time work: Year Month Day		b) Gradual return to work: Year Month Day		
<b>18</b> Since the last report, have you consulted a health professional, received treatments or undergone any examinations? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, please provide details below.</b> Hospitals and physicians consulted during your current disability: Name and address of hospital or physician Date Treatments/operations _____ _____ _____				
<b>19</b> What medication are you currently taking? _____				
<b>20</b> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, which organization?</b> _____ <b>Date of application:</b> Year Month Day <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Under assessment <b>Other:</b> Name of insurance company _____ <b>File No.</b> _____ <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Under assessment				
<b>21</b> Please provide any other information relevant to this application that has not been provided in the answers above: _____				
<b>22</b> I hereby declare that these answers are true and complete. _____ Signature of Insured Date Year Month Day				



**Section to be completed by the insured**

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

<p>1 Last Name: _____</p> <p>3 Contract No.: _____</p>	<p>2 First Name: _____</p> <p>4 Social Insurance No.: _____</p> <p>5 Date of Birth: _____</p>
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**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)

<b>M Md S</b>	<b>M Md S</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**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 Would the patient benefit from assistance with a view to returning to work? No  Yes

3.11 Approximate duration of disability: No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_ Indefinite  or date of return to work \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

3.12 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.

<p>1 Last Name: _____</p> <p>3 Contract No.: _____</p>	<p>2 First Name: _____</p> <p>4 Social Insurance No.: _____</p> <p>5 Date of Birth: _____</p>
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**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
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 <input type="checkbox"/>	Yes <input type="checkbox"/>	Treatment centre	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Psychologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	CLSC	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Social worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Day hospital	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Other health professional	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Group therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Individual therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>

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):

<input type="checkbox"/> Personal or interpersonal problems	<input type="checkbox"/> Loss of employment or layoff	<input type="checkbox"/> Occupational problems
<input type="checkbox"/> Marital or family problems	<input type="checkbox"/> Alcohol or drug abuse and/or gambling problems	
<input type="checkbox"/> 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 Would the patient benefit from assistance with a view to returning to work? No  Yes

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

3.8 Approximate duration of disability: No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_ Indefinite  or Date of return to work \_\_\_\_\_ Year | Month | Day |

3.9 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.**