Checklist - Documents required for a new disability insurance claim at SSQ Insurance

In the days preceding the date of eligibility for short-term disability insurance benefits, a claim must be submitted to SSQ Insurance. Here is a list of documents and forms required for a new disability insurance claim.

Important: Please wait to have all the documents and duly completed forms before sending your claim to SSQ Insurance in one mailing.

Disability insurance benefit claim form

- Insured's statement
- Attending physician's statement

Medical documents

- Complete medical file compiled since the beginning of the disability including all independent medical examinations (if applicable)
- Exam and test results
- Clinical notes
- Any other available medical document you deem relevant

There are three ways to return your documents to us:

- **By email**: disability@ssq.ca
- **By fax**: 418-651-5569
- **By mail**:
  SSQ Insurance | Disability Management and Life Insurance
  2525 Laurier Boulevard, Box 10500, Stn Sainte-Foy
  Quebec City, QC G1V 4H6

Questions?

You may contact us Monday to Friday, from 8:30 a.m. to 4:30 p.m., by calling **418-651-2307** or **1-888-651-2307**.

Application for Disability Insurance Benefits
Home Childcare Providers

Statement of insured

Last name _____ First name _____

Group or policy no. | Certificate no.

Contract no.

Mailing address _____ Postal code

Telephone (home) _____ Mobile _____ Date of birth (Y Y Y Y M M D D) ☐ F ☐ M Sex

Status: ☐ Single ☐ Single-parent ☐ Married or common-law

Dependents: **Spouse:** ☐ No ☐ Yes **Children:** ☐ No ☐ Yes How many: _____ Age of YOUR children: _____

Since your interruption of work, have you held any other employment? ☐ No ☐ Yes → Start date: (Y Y Y Y M M D D)

If yes, specify the nature of the employment

Have you received or are you receiving remuneration for this employment?

Is the disability the result of an accident? ☐ No ☐ Yes → Describe the circumstances, date and place.

Are you receiving or have you applied to receive any of the following benefits?

PROGRAM	NO	IF YES						IF DECLINED	
		Under review	Accepted	Ref. no.	Amount	Payment frequency	Declined	Do you intend to appeal this decision? No	Yes
PROGRAM QPIP (maternity leave benefits) If accepted, start date of benefits: (Y Y Y Y M M D D)	☐	☐	☐		$		☐	☐	☐
Workplace accident or occupational disease (CNESST)	☐	☐	☐		$		☐	☐	☐
Compensation for victims of crime (IVAC)	☐	☐	☐		$		☐	☐	☐
Automobile Insurance Act or other compensation program (SAAQ)	☐	☐	☐		$		☐	☐	☐
PLAN Retraite Québec: ☐ disability pension ou ☐ retirement pension	☐	☐	☐		$		☐	☐	☐
Canada Pension Plan: ☐ disability benefits or ☐ retirement pension	☐	☐	☐		$		☐	☐	☐
Health insurance plan or social welfare	☐	☐	☐		$		☐	☐	☐
Other group insurance plan: _____	☐	☐	☐		$		☐	☐	☐

NOTE: PLEASE INCLUDE A COPY OF ALL DOCUMENTS RECEIVED FROM THE ABOVE ORGANIZATIONS, INCLUDING ANY BENEFIT PAYMENT STATEMENTS.

PROFESSIONAL ACTIVITIES

Please check off the days normally worked:

☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Number of hours worked in a regular week: _____

How long have you been accredited as a childcare service provider? _____

Basic job description:

How many children are you accredited for? _____

At the time of your work interruption, did you have this same number of children in your care? _____

Please specify the age range of your children per category below:

1 month - 1 year _____ 1 - 2 years _____ 2 - 3 years _____

3 - 4 years _____ 4 - 5 years _____ 5 - 6 years _____

PROFESSIONAL ACTIVITIES (Cont'd)

Before your interruption of work, was anyone else working with you? _____

If so, does this employee work: **Full time?** ☐ No ☐ Yes **Part time?** ☐ No ☐ Yes

During your interruption of work, your childcare service will: ☐ Remain open ☐ Close

If your childcare remains open, will someone be replacing you? ☐ No ☐ Yes

If so, will they be renumerated? ☐ No ☐ Yes

In your opinion, is your work environment preventing you from doing your job? ☐ No ☐ Yes

If yes, specify: _____

Date you stopped working: Y Y Y Y M M D D Number of hours worked that day: _____

Have you returned to work? ☐ No ☐ Yes → Date: Y Y Y Y M M D D

If you haven't returned to work, what is the probable date of your return: Y Y Y Y M M D D

Is your childcare service under investigation or has its licence been suspended by the CDPDJ (Commission des droits de la personne et des droits de la jeunesse)? ☐ No ☐ Yes

If yes, specify: _____

If you are pregnant, have you or will you submit an application for preventive leave to the CNESST? ☐ No ☐ Yes

Expected delivery date: Y Y Y Y M M D D

Please describe how your disability prevents you from working: _____

a) Briefly describe your daily activities since you've stopped working: _____

b) What are your childcare service duties during your disability? _____

Are there any factors related to your duties that may have an impact on your return to work? _____

DIRECT DEPOSIT REGISTRATION

MANDATORY ENROLMENT FOR DIRECT DEPOSIT (IMPORTANT: Please sign the authorization below and enclose a cheque specimen marked "VOID").

I authorize SSQ, Life Insurance Company Inc. to deposit my disability insurance benefits into my bank account.

Participant's signature _____ Date Y Y Y Y M M D D

AUTHORIZATION AND SIGNATURE

I hereby certify that the information provided above is accurate. For the purposes of managing my benefit claim, I authorize SSQ, Life Insurance Company Inc. (herein after SSQ) to obtain personal information about me, medical information in particular, from the following:

- Physicians or other health professionals
- Medical or paramedical establishments or clinics
- Policyholder
- Other insurance or reinsurance companies
- Any public or parapublic organizations such as Employment Insurance, CNESST or SAAQ
- Any other individual or institution

I also discharge the above from their confidentiality obligation and authorize them to disclose the requested information to SSQ.
I also authorize SSQ to disclose the information in my file to one or more physicians of their choice for evaluation purposes.
Copies of this document have the same value as the original.

Participant's signature _____ Date Y Y Y Y M M D D

IMPORTANT

The following must be duly completed and signed:

By the participant

- Participant's statement

By the attending physician

- Declaration of attending physician

You have several options to return your documents to us:
• **By email:** disability@ssq.ca • **By fax:** 418-651-5569 • **By mail:** SSQ Insurance, Disability Insurance, P.O. Box 10500, Stn Sainte-Foy, Quebec City QC G1V 4H6

If you are registered on the ACCESS | Plan member's website, you'll receive an email at every important processing stage of your disability file.
If you are not yet registered, go to SSQ.CA and register for the ACCESS | Plan members website by providing an email address that you can access during your disability leave.

ATTENDING PHYSICIAN'S STATEMENT – DISABILITY CLAIM

SSQ, Life Insurance Company Inc. | Disability Management & Life Insurance
2525 Laurier Boulevard | P.O. Box 10500 | Station Sainte-Foy | Quebec (Quebec) G1V 4H6
418-651-2307 or 1-888-651-2307 | Fax: 418-651-5569

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

Plan Member/Employee Information and Consent — To Be Completed By Patient

☐ Male
☐ Female

Plan Member/Employee Name : _____
Last Name First Name

Date of Birth (Y Y Y Y M M D D) | Height | Weight | Home Phone # (+ Area Code) | Cell Phone # (+ Area Code)

Address _____
Street City Province Postal Code

Employer's Name | Plan Contract # | Member Certificate #

Last Date Worked (Y Y Y Y M M D D) | **Date Returned to Work or Expected Return to Work Date** (Y Y Y Y M M D D)

Questions — To Be Completed By Physician

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete sections 1 to 4 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

1) Diagnosis

Primary Diagnosis: _____

Secondary and/or Complications: _____

Does the interruption of work result from problems related to:

☐ marital/family life
☐ professional problems
☐ personnal or interpersonnal problems
☐ alcohol or drug abuse and/or gambling problems

If Childbirth - Expected or Actual Delivery Date (Y Y Y Y M M D D) Vaginal ☐ C-Section ☐

Occupational Illness/injury? ☐ Yes ☐ No
If yes, date of event: (Y Y Y Y M M D D)

Auto accident? ☐ Yes ☐ No
If yes, date of event: (Y Y Y Y M M D D)

Date of first visit to you pertaining to this condition: (Y Y Y Y M M D D)

First date of work absence due to condition: (Y Y Y Y M M D D)

2) Hospitalization

Is/was patient hospitalized? ☐ **or** had day surgery? ☐

(Y Y Y Y M M D D) Date of admittance | (Y Y Y Y M M D D) Date of discharge | Institution Name

If surgery was performed please provide date and description of surgery:

(Y Y Y Y M M D D) Date | Description

3) Treatment (drug, dosage, physiotherapy, other):

4) Prognosis Please provide the prognosis for recovery:

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

If yes, date: Y Y Y Y M M D D Treatment Provider:

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

Degree of severity of all symptoms:

☐ Mild ☐ Moderate ☐ Severe ☐ with psychotic elements

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐

Approximate duration of disability: No. of days _____ No. of weeks_____

☐ unspecified or date of return to work Y Y Y Y M M D D
☐ part-time
☐ full-time
☐ gradual return

Specify:

5) Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Please attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist | Specialty | Date of Visit (Y Y Y Y M M D D)

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

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

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

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

Notice to Physician

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 _____ Date Signed : Y Y Y Y M M D D
(please print)

Physician's Specialty _____ License Number: _____

Address: _____ _____ _____
Street City Province Postal Code

Telephone # (+ area code): Fax # (+ area code):

Signature: _____