SSQ insurance

Plan Member Confirmation of Injury/Illness Form – Ongoing claim

In recognition of the increasing pressure on our medical clinics and hospitals due to the COVID-19 pandemic, we may not, at the outset, require an Attending Physician's Statement as part of your ongoing disability claim. Please complete this form only in the event you were unsuccessful in having your health professional complete one, or if you were unable to consult with your health professional. This is a time limited exception as we move through the current situation. Please note however, we reserve the right to request further medical information depending on the information provided below.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms, any test results, and any medical treatment you may have received for your condition.

Once the form is completed, send this claim to the following addresses:
- residents of Quebec: salaire@ssq.ca
- residents of other provinces in Canada: disabilitymanagement@ssq.ca

Member Details

Group Number: ______________________ Certificate Number: ______________________

Employee Name: ______________________ Plan Sponsor Name: ______________________

Update to your ongoing claim

☐ Extension of benefits for a current claim

☐ New/additional condition

☐ Change in my existing condition (i.e. medication/dosage, testing, treatment)

1. Diagnosis

   Primary: ______________________

   Secondary and/or complications: ______________________

   If Childbirth - Expected or Actual Delivery Date: Year | Month | Day ☐ Vaginal ☐ C-Section

2. Please list the symptoms associated with your illness/injury and the severity of each symptom. Please also describe how your symptoms are currently impacting your ability to work.

3. Please provide details about what you have discussed with your employer regarding how you could be accommodated, including work from home?

4. Do you have an anticipated return to work date? ☐ Yes ☐ No If so, when: Year | Month | Day

5. Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)?

6. Is your condition related to an Occupational Illness/injury? ☐ Yes ☐ No If yes, date of event:

7. Is your condition related to an Auto accident? ☐ Yes ☐ No If yes, date of event:

8. Have you been hospitalized for this condition since the last update? ☐ Yes ☐ No Date of admittance

***If you have been hospitalized for this condition, you must obtain the discharge notes and submit these with your update.

9. Date of discharge ____ Year ____ Month ____ Day Name of institution: ____

10. Have you had surgery for this condition since the last update? ☐ Yes ☐ No If yes, please provide date and description of surgery

Date ____ Year ____ Month ____ Day Description: ____

11. Current treatment description (i.e. medication, dosage)

12. Have you receive therapy for your condition? ☐ Yes ☐ No

If yes, please provide information about our therapist

Name: ____ Location: ____ Phone: ____

Specialty: ____

What date did you last see your therapist?

Are you continuing to receive therapy from this health professional, including virtual therapy? ☐ Yes ☐ No Frequency: ____

Please elaborate:

13. Are you following the plan outlined by your health professional (i.e. medication, therapy, home exercise) ☐ Yes ☐ No

If no, please explain:

14. Have you been referred for any testing? ☐ Yes ☐ No Type of testing: ____ Date: ____ Year ____ Month ____ Day

Results (if known) – please attach a copy of the testing report if available

15. Have you been referred to a specialist? ☐ Yes ☐ No

Name of specialist: ________ Specialty ________ Date of visit: Year Month Day

Results of consultation (if known) – please attach a copy of the consultation report if available

I certify that the statements in this form are true and complete and I understand that further information may be required to validate my claim.

We reserve the right to pursue recovery of benefits improperly paid for any reason, fraud or otherwise.The submission of fraudulent claims is a criminal offence and is taken seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

Please note that the authorization you signed on the Application for Disability Insurance Benefits form is also applicable to this document.

Name: ________ Phone Number: ________

Email: ________ Cell Phone Number: ________

Signature: ________ Date: Year Month Day

Have questions about your claim? Contact the Customer Centre at 1-888-651-2307 for Quebec customers and 1-866-885-6772 for customers outside the province of Quebec.

For more information on the novel coronavirus, go to the Public Health Agency of Canada’s website at https:// www.canada.ca/en/public-health.html