SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

Disability Insurance Claim
ATTENDING PHYSICIAN'S STATEMENT
Physical conditions

INSTRUCTIONS
Please answer all questions fully – it helps us provide a better service.
This form can be completed in ink (please print), however, the form must be signed and dated by all parties and the ORIGINAL signed form **in its entirety** must be returned at the following address:
Disability insurance services
1610, Bellefeuille street, suite 201,
Trois-Rivières, QC
G9A 6H7

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

POLICY NO.

INFORMATION ABOUT THE PATIENT

SURNAME AND FIRST NAME	SEX ☐ M ☐ F	DATE OF BIRTH | Y Y Y Y | M M | D D |
NAME AT BIRTH	HEIGHT	WEIGHT

DIAGNOSIS

PRIMARY DIAGNOSIS	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED | Y Y Y Y | M M | D D |
DATE OF PATIENT'S FIRST VISIT FOR HIS/HER CURRENT CONDITION | Y Y Y Y | M M | D D |	DATE OF PATIENT'S FIRST VISIT DURING PRESENT PERIOD OF ABSENCE FROM WORK | Y Y Y Y | M M | D D |

IF THE PATIENT HAS A CARDIAC CONDITION, WHAT IS HIS/HER CURRENT FUNCTIONAL CAPACITY BASED ON THE AMERICAN HEART ASSOCIATION CLASSIFICATIONS:

☐ Class 1 *(No Limitation)* ☐ Class 2 *(Slight Limitation)* ☐ Class 3 *(Marked Limitation)* ☐ Class 4 *(Severe Limitation)*

PATIENT'S BLOOD PRESSURE *Current:* _____ *Previous:* _____	DATE PREVIOUS BLOOD PRESSURE WAS TAKEN | Y Y Y Y | M M | D D |

IF YOUR PATIENT HAS A BACK/SPINAL CONDITION, HAVE AN X-RAY, MRI OR ANY OTHER TESTS BEEN PERFORMED?

☐ No ☐ Yes *If yes, please attach a copy of the results of any tests which may have been performed.*

IS THERE A SECONDARY DIAGNOSIS OR ADDITIONAL COMPLICATION WHICH MIGHT AFFECT THE DURATION OF ABSENCE FROM WORK?

☐ No ☐ Yes *If yes, please provide details.*

PLEASE PROVIDE A COMPLETE LIST OF THE PATIENT'S SYMPTOMS (INCLUDING SEVERITY AND FREQUENCY), IDENTIFYING WHICH OF THE SYMPTOMS LISTED YOU HAVE OBJECTIVELY OBSERVED.

WHAT ARE THE PATIENT'S CURRENT LIMITATIONS (THINGS THAT HE/SHE **CANNOT** DO)? PLEASE BE SPECIFIC.

WHAT ARE THE PATIENT'S CURRENT RESTRICTIONS (THINGS THAT HE/SHE **SHOULD NOT** DO)? PLEASE BE SPECIFIC.

IS YOUR PATIENT COMPETENT TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS?

☐ No ☐ Yes

DATE THE PATIENT STOPPED WORKING BASED ON YOUR RECOMMENDATIONS | Y Y Y Y | M M | D D |	DATE OF A POTENTIAL RETURN TO WORK, IF DISCUSSED WITH THE PATIENT | Y Y Y Y | M M | D D |

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION?

☐ No ☐ Yes *If yes, please provide dates and describe.*

IS THE PATIENT'S CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF HIS/HER EMPLOYMENT?

☐ No ☐ Yes *If yes, please provide details.*

IF THE PATIENT WAS/IS PREGNANT, PLEASE INDICATE THE DATE OR EXPECTED DATE OF CONFINEMENT.

\| Y Y Y Y \| M M \| D D \|

SSQ Financial Group
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SSQ Evolution
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Disability Insurance Claim
ATTENDING PHYSICIAN'S STATEMENT
Physical conditions

POLICY NO.

TREATMENT

FREQUENCY OF PATIENT VISITS:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____

PLEASE DETAIL THE PATIENT'S PAST AND PRESENT TREATMENT (E.G. DATE AND TYPE OF SURGERY) AS WELL AS RESPONSE TO TREATMENT.

HAS THE PATIENT BEEN HOSPITALIZED?

☐ No ☐ Yes *If yes, please provide the name of the hospital(s) and the dates of confinement.*

PLEASE LIST ALL OF THE MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING, INCLUDING DOSAGE AND DATE PRESCRIBED.

MEDICATION	DOSAGE	DATE PRESCRIBED
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D

IF THIS PATIENT WAS REFERRED TO YOU, PLEASE PROVIDE THE NAME OF THE REFERRING PHYSICIAN.

IF YOU HAVE REFERRED THE PATIENT TO A SPECIALIST(S), PLEASE PROVIDE THE NAME(S) OF THE SPECIALIST(S) AND AREA OF SPECIALITY.

SIGNATURE **X**	DATE | Y Y Y Y | M M | D D |
NAME (PLEASE PRINT)	SPECIALITY
ADDRESS	
TELEPHONE	FAX

THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED FOR THE COMPLETION OF THIS FORM.

SSQ Financial Group
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SSQ Evolution
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Disability Insurance Claim
ATTENDING PHYSICIAN'S STATEMENT
Psychological conditions

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POLICY NO.

INFORMATION ABOUT THE PATIENT

SURNAME AND FIRST NAME	SEX ☐ M ☐ F	DATE OF BIRTH | Y Y Y Y | M M | D D |
NAME AT BIRTH	HEIGHT	WEIGHT

DIAGNOSIS

PLEASE INDICATE THE DIAGNOSIS USING DSM – IV AXIAL EVALUATION NOMENCLATURE AND CODE NUMBERS

I

II

III

IV

V

IS THERE A SECONDARY DIAGNOSIS OR ADDITIONAL COMPLICATION WHICH MIGHT AFFECT THE DURATION OF ABSENCE FROM WORK?
☐ No ☐ Yes *If yes, please provide details.*

PLEASE PROVIDE A COMPLETE LIST OF THE PATIENT'S SYMPTOMS (INCLUDING SEVERITY AND FREQUENCY), IDENTIFYING WHICH OF THE SYMPTOMS LISTED YOU HAVE OBJECTIVELY OBSERVED.

PLEASE DESCRIBE THE PATIENT'S INITIAL REASON FOR SEEKING TREATMENT. WAS THERE A PRECIPITATION EVENT?

DATE OF PATIENT'S FIRST VISIT FOR HIS/HER CURRENT CONDITION | Y Y Y Y | M M | D D |	DATE SYMPTOMS FIRST APPEARED | Y Y Y Y | M M | D D |

DATE OF PATIENT'S FIRST VISIT DURING PRESENT PERIOD OF ABSENCE FROM WORK
\| Y Y Y Y \| M M \| D D \|

IS YOUR PATIENT'S CONDITION CAUSED DIRECTLY OR INDIRECTLY BY HIS/HER EMPLOYMENT?
☐ No ☐ Yes *If yes, please provide details.*

WHAT ARE THE PATIENT'S CURRENT LIMITATIONS (THINGS THAT HE/SHE **CANNOT** DO)? PLEASE BE SPECIFIC.

WHAT ARE THE PATIENT'S CURRENT RESTRICTIONS (THINGS THAT HE/SHE **SHOULD NOT** DO)? PLEASE BE SPECIFIC.

IS YOUR PATIENT COMPETENT TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS?
☐ No ☐ Yes

DATE THE PATIENT STOPPED WORKING BASED ON YOUR RECOMMENDATIONS | Y Y Y Y | M M | D D |	DATE OF A POTENTIAL RETURN TO WORK, IF DISCUSSED WITH THE PATIENT | Y Y Y Y | M M | D D |

SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

Disability Insurance Claim
ATTENDING PHYSICIAN'S STATEMENT
Psychological conditions

POLICY NO.

TREATMENT

FREQUENCY OF PATIENT VISITS:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____

PLEASE DETAIL THE PATIENT'S PAST AND PRESENT TREATMENT (INCLUDING PSYCHOTHERAPY), RESPONSE TO TREATMENT AND COMPLIANCE.

HAS THE PATIENT BEEN HOSPITALIZED?

☐ No ☐ Yes *If yes, please provide the name of the hospital(s) and the dates of confinement.*

PLEASE LIST ALL OF THE MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING, INCLUDING DOSAGE AND DATE PRESCRIBED.

MEDICATION	DOSAGE	DATE PRESCRIBED
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D

FUNCTIONAL CAPACITIES EVALUATION

PLEASE PROVIDE YOUR OPINION AS TO THE EXTENT OF THE PATIENT'S IMPAIRMENT IN PERFORMING THE FOLLOWING ON A SUSTAINED BASIS:

None: No impairment in this area.
Mild: Suspected impairment of slight importance which does not affect functional ability.
Moderate: Impairment affects but does not preclude ability to function.
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

	NONE	MILD	MODERATE	MODERATELY SEVERE	SEVERE
1. Ability to relate to friends and family members	☐	☐	☐	☐	☐
2. Ability to attend to personal care (bathing, cooking, etc.)	☐	☐	☐	☐	☐
3. Ability to carry out household chores	☐	☐	☐	☐	☐
4. Ability to relate to co-workers and supervisors	☐	☐	☐	☐	☐
5. Perform work where contact with others will be minimal	☐	☐	☐	☐	☐
6. Understand, carry out and remember instructions	☐	☐	☐	☐	☐
7. Perform tasks involving minimal intellectual effort or repetitive tasks	☐	☐	☐	☐	☐
8. Perform varied tasks	☐	☐	☐	☐	☐
9. Ability to follow a regular work schedule	☐	☐	☐	☐	☐
10. Make independent judgements	☐	☐	☐	☐	☐
11. Perform intellectually complex tasks requiring higher levels of reasoning, math and language skills	☐	☐	☐	☐	☐
12. Supervise or manage others	☐	☐	☐	☐	☐

SIGNATURE **X**	LICENCE NO:	DATE | Y Y Y Y | M M | D D |
NAME (PLEASE PRINT)	SPECIALITY	
ADDRESS		
TELEPHONE	FAX	

THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED FOR THE COMPLETION OF THIS FORM.

SSQ Financial Group
Values in the right place

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Disability Insurance Claim
INSURED'S STATEMENT

INSTRUCTIONS
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G9A 6H7
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	POLICY NO.

GENERAL INFORMATION

SURNAME AND FIRST NAME	SEX	DATE OF BIRTH
	☐ M ☐ F	| Y Y Y Y | M M | D D |

SOCIAL INSURANCE NUMBER	TELEPHONE NUMBER	CERTIFICATE NO.	LANGUAGE
			☐ English ☐ French

ADDRESS

NAME OF EMPLOYER (AND DIVISION IF DIFFERENT)	OCCUPATION (JUST PRIOR TO LAST DAY WORKED)	ORIGINAL DATE OF HIRE
		| Y Y Y Y | M M | D D |

TAX EXEMPT
☐ No ☐ Yes *If yes, please state reason.*

OTHER CURRENT EMPLOYER
☐ No ☐ Yes *If yes,* please name.

CLAIM INFORMATION

WAS THE REASON YOU STOPPED WORKING DUE TO *(IF THE REASON WAS A MOTOR VEHICLE ACCIDENT, PLEASE SUBMIT A POLICE OR COLLISION REPORT, EXCEPT IN QUÉBEC):*
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident (not while working) ☐ Occupational illness or work accident

IF YOU HAVE SUFFERED AN INJURY, PLEASE DESCRIBE HOW, WHEN AND WHERE THE INJURY OCCURRED:

WHAT WAS THE LAST DAY YOU WORKED?	WERE YOU PERFORMING:
| Y Y Y Y | M M | D D |	☐ Your regular duties ☐ Modified duties

WAS THIS A FULL DAY?
☐ No ☐ Yes *If no, how many hours did you work on your last day?*

DATE YOU WERE FIRST UNABLE TO WORK	DATE YOU FIRST NOTICED SYMPTOMS	DATE YOU WERE FIRST TREATED BY A PHYSICIAN
| Y Y Y Y | M M | D D |	| Y Y Y Y | M M | D D |	| Y Y Y Y | M M | D D |

PLEASE DESCRIBE ALL OF YOUR SYMPTOMS, INCLUDING FREQUENCY AND SEVERITY.

HAVE YOU EVER HAD THE SAME OR SIMILAR ILLNESS OR INJURY?
☐ No ☐ Yes *If yes, please provide the dates and name(s) of physicians who treated you at the time.*

PLEASE DESCRIBE THE MAJOR DUTIES OF YOUR OCCUPATION.

PLEASE DESCRIBE WHY YOU ARE UNABLE TO PERFORM THE DUTIES OF YOUR OCCUPATION.

DO YOU HAVE AN EXPECTED DATE OF RETURN TO WORK?
☐ No ☐ Yes *If yes, please provide the date.*

HEALTH CARE PROFESSIONAL INFORMATION

NAME		CONSULTED FROM | Y Y Y Y | M M | D D | TO | Y Y Y Y | M M | D D |
ADDRESS		
TELEPHONE NUMBER	FAX NUMBER	SPECIALITY
NAME		CONSULTED FROM | Y Y Y Y | M M | D D | TO | Y Y Y Y | M M | D D |
ADDRESS		
TELEPHONE NUMBER	FAX NUMBER	SPECIALITY
NAME		CONSULTED FROM | Y Y Y Y | M M | D D | TO | Y Y Y Y | M M | D D |
ADDRESS		
TELEPHONE NUMBER	FAX NUMBER	SPECIALITY

OTHER INCOME INFORMATION

IF YOU HAVE APPLIED FOR, OR ARE RECEIVING ANY INCOME FROM ANY OF THE FOLLOWING SOURCES, PLEASE COMPLETE THE FOLLOWING AND SUBMIT A COPY OF YOUR NOTICE OF ACCEPTANCE, IF APPLICABLE.

SOURCE	CLAIM NO., CONTACT NAME, TELEPHONE NO.	HAVE YOU APPLIED? YES	HAVE YOU APPLIED? NO	ARE YOU RECEIVING PAYMENT? YES	ARE YOU RECEIVING PAYMENT? NO	ARE YOU RECEIVING PAYMENT? PENDING	MONTHLY AMOUNT
Worker's Comp / CSST		☐	☐	☐	☐	☐	
Canada Pension Plan – Disability		☐	☐	☐	☐	☐	
Canada Pension Plan – Retirement		☐	☐	☐	☐	☐	
Québec Pension Plan (QPP) – Disability		☐	☐	☐	☐	☐	
Québec Pension Plan (QPP) – Retirement		☐	☐	☐	☐	☐	
Employment Insurance		☐	☐	☐	☐	☐	
Auto Insurance		☐	☐	☐	☐	☐	
Other insurer		☐	☐	☐	☐	☐	

NAME OF CREDIT INSTITUTION (PLEASE PRINT)	LOAN NUMBER
ADDRESS OF CREDITOR	
SIGNATURE OF INSURED **X**	DATE | Y Y Y Y | M M | D D |

PLEASE RETURN COMPLETED CLAIM FORM WITH THE "CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION" FORM.

SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
(Accident and Sickness Claims)

I authorize SSQ, Life Insurance Company Inc., its legal agents, services providers and its reinsurers to collect, use, and disclose personal information about me as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ, Life Insurance Company Inc.;

for the following purposes:
- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and setting claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ, Life Insurance Company Inc. and its legal agents will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ, Life Insurance Company Inc. Within SSQ, Life Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Disability insurance services
1610, Bellefeuille street, suite 201,
Trois-Rivières, QC G9A 6H7

This consent shall be valid for the length of time necessary for SSQ, Life Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ, Life Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ, Life Insurance Company Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

	POLICY NO.
DATE OF THE OCCURRENCE | Y , Y , Y , Y | M , M | D , D |	CAUSE (ACCIDENT, ILLNESS, ETC.)
SIGNATURE OF INSURED **X**	DATE OF SIGNATURE | Y , Y , Y , Y | M , M | D , D |
PRINT NAME OF INSURED	TELEPHONE NUMBER
ADDRESS	

Where the claim is for Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

SIGNATURE OF AUTHORIZED REPRESENTATIVE **X**	DATE OF SIGNATURE | Y , Y , Y , Y | M , M | D , D |
PRINT NAME OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO THE INSURED

The completed authorization can be returned at the following address:

Disability insurance services
1610, Bellefeuille street, suite 201,
Trois-Rivières, QC G9A 6H7

SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

Disability Insurance Claim
EMPLOYER'S STATEMENT

INSTRUCTIONS
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POLICY NO.

EMPLOYER INFORMATION

NAME OF POLICYHOLDER

TELEPHONE NUMBER

INSURED INFORMATION

NAME OF POLICYHOLDER

ADDRESS

SURNAME AND FIRST NAME

SEX
☐ M ☐ F

DATE OF BIRTH
| Y Y Y Y | M M | D D |

PERMANENT EMPLOYEE?
☐ No ☐ Yes

WAS THE EMPLOYEE ACTIVELY AT WORK WHEN THE ABSENCE BEGAN / LOSS OCCURRED?
☐ No ☐ Yes *If no, please provide details.*

PARTICIPANT'S DATE OF HIRE
| Y Y Y Y | M M | D D |

DATE OF PARTICIPANT'S LAST DAY OF WORK
| Y Y Y Y | M M | D D |

IF ALREADY BACK AT WORK, WHAT WAS THE START DATE?
☐ PART-TIME: | Y Y Y Y | M M | D D | ☐ FULL-TIME: | Y Y Y Y | M M | D D |

WHAT WAS THE PARTICIPANT'S MAIN REASON FOR ABSENCE:
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident (not while working) ☐ Occupational illness or work accident

PLEASE INDICATE THE NUMBER OF HOURS PER WEEK AND THE NUMBER OF WEEKS PER YEAR THE PARTICIPANT IS WORKING?
_____ hours / week _____ weeks / year

WHAT WAS THE PARTICIPANT'S GROSS WEEKLY SALARY AS OF HIS/HER LAST DAY OF WORK?
_____ $

WAS THE PARTICIPANT:
☐ Salaried ☐ Hourly

HAS THE PARTICIPANT SUBMITTED A CLAIM TO THE FOLLOWING GOVERNMENT BODIES?
☐ WSIB / WCB / CSST ☐ EI ☐ CPP ☐ QPP (RRQ) ☐ Provincial automobile insurance board

OCCUPATIONAL INFORMATION

WHAT WAS THE PARTICIPANT'S REGULAR OCCUPATION IMMEDIATELY PRIOR TO HIS/HER STOPPING WORK?

WERE THE PARTICIPANT'S DUTIES MODIFIED FROM HIS/HER REGULAR OCCUPATION?
☐ No ☐ Yes

PLEASE DESCRIBE THIS EMPLOYEE'S REGULAR OCCUPATION (OR ATTACH A COPY OF THE COMPANY'S JOB DESCRIPTION) AS WELL AS ANY MODIFICATIONS, IF ANY.

PLEASE DESCRIBE WORK ENVIRONMENT (E.G. TEMPERATURE, NOISE LEVELS, CHEMICAL / DUST EXPOSURE, ETC.)

DOES THE PARTICIPANT WEAR PERSONAL PROTECTIVE EQUIPMENT (E.G. SAFETY GLASSES / FOOTWEAR, RESPIRATORY PROTECTION, EAR PROTECTION, ETC.)?
☐ No ☐ Yes *If yes, please describe.*

POLICY NO.

PHYSICAL DEMANDS ANALYSIS

THE FOLLOWING PHYSICAL DEMANDS ANALYSIS OF THE PARTICIPANT'S OCCUPATION IS TO BE COMPLETED BY HIS/HER SUPERVISOR.
IN THE APPROPRIATE COLUMN, PLEASE SPECIFY THE AVERAGE AMOUNT OF TIME (IN HOURS) THE FOLLOWING ACTIVITIES ARE REGULARLY PERFORMED:
I) at any time without a break *(approximately)* **and;**
II) in total throughout the day *(approximately)*

				I	II
1. Sitting					
2. Standing					
3. Driving					
4. Bending					
5. Climbing up and down the stairs					
6. Lifting	0 – 10 pounds ☐ 20 – 50 pounds ☐ With lifting device? ☐ Yes		10 – 20 pounds ☐ 50 pounds + ☐ ☐ No		
7. Pushing / Pulling	0 – 10 pounds ☐ 20 – 50 pounds ☐		10 – 20 pounds ☐ 50 pounds + ☐		

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND COMPLETE.

SIGNATURE **X**	DATE Y Y Y Y M M D D
NAME (PLEASE PRINT)	
JOB TITLE	TELEPHONE