



DISABILITY

CLAIMANT'S STATEMENT

The patient is responsible for any charges made for completing this form.

- Waiver of premiums
Premium waiver and total disability income
Complementary income

- Anticipated benefit \$
CID
Home Protection Plan
Momentum
Pick-A-Term
Loss of sight or limb(s)

Claim no.:
New file

1. Contract numbers

Grid for contract numbers

Agent, Agency, Code, S.U.

2. Insured's last name

3. First name(s), Date of birth

4. No., 5. Street, 6. Apt.

7. City, 8. Province, 9. Postal code

10. Phone no. (home), 11. Social Insurance Number

12. Occupation at time of disability

13. Gross monthly income \$

14a. Name of employer

15a. Are you still employed there? Yes No

14b. Address of employer

15b. If not, since when? Y M D

16. Date you stopped working for medical reasons

17. Are you still completely unable to work? Yes No -> Since

18. Have you returned to work part-time?

Your duties Any other duties Yes No

19. Have you resumed working completely? Yes -> Since No

20a. Have you returned to school?

Yes -> Since No

20b. What kind of courses are you taking? Number of hours per week

21. Details of accident or nature of illness (If accident, how did it occur?)

22. Date of accident or beginning of illness

23. Have you ever had the same or a similar illness before? Yes -> State when No

24. Name of attending physician

25. Address of attending physician

26. Name of hospital

27. Address of hospital

28. Hospitalization dates

29. Have you made a claim or intend to submit a claim to a government agency?

- No
Yes -> Which one? CSST, Régie des rentes du Québec, SAAQ, Canada Pension Plan, WCB, Other:

N.B. Enclose copy of letter of acceptance and copy of the last cheque stub received

Amount: \$

30. Name of any other company with which you have filed or intend to file a claim for this disability

Individual policy, Group insurance, Mortgage disability insurance

N.B. Enclose copy of letter of acceptance and copy of the last cheque stub received

Monthly income \$

I certify that the answers given above are complete and true.

Signed at Date Y M D

Witness

Insured

PLEASE DO NOT DETACH THE AUTHORIZATION

AUTHORIZATION

I hereby authorize any healthcare professional, public or private health organization or any other public or private organization holding information concerning me, to supply this information to Industrial Alliance Insurance and Financial Services Inc. or its authorized agent for the assessment of my claim. A photocopy of this authorization shall be as valid as the original.

Signed at Date Y M D

Witness

Insured

Address Postal code

Address Postal code

Telephone

Telephone

Patient's name \_\_\_\_\_ Date of birth Y | M | D

1. Previous medical history
a) Symptoms first appeared or accident happened on Y | M | D
b) Date total disability began Y | M | D
c) Has patient already had same or similar condition?
d) Is condition due to injury or sickness arising from patient's employment?
e) If condition is due to pregnancy, what is (or was) the expected date of delivery?
f) If relapse, date total disability reoccurred:
g) Name of other attending physicians

2. Diagnosis of present condition
a) Primary
b) Secondary (if applicable)
c) Results of current X-rays, E.K.G. or any other special tests
d) Describe the conditions that currently prevent the patient from returning to his/her occupation. Are they temporary? permanent?
e) Additional conditions which might affect the duration of disability

3. Treatment
a) Date of first visit for present period of disability Y | M | D
b) Date of last visit Y | M | D
c) Frequency of visits Weekly Monthly Other (specify)
d) Is patient following recommended treatment program? Yes No
e) Nature and duration of treatment

4. Hospitalization
a) Name of hospital
b) Hospitalized from Y | M | D to Y | M | D
c) If surgery performed, describe: Date Y | M | D

5. Physical incapacities
a) Is patient: Ambulatory? House confined? Bedridden? Hospitalized?
b) If ambulatory or house confined, please complete the section below
No restriction; capable of all physical activities
Moderate restriction; normal duties with moderate effort
Marked restriction; light duties
Complete restriction; total incapacity

6. Nervous or psychiatric disorders
a) What are the subjective and objective symptoms observed?
b) What are the psychosocial stressors?
c) Has the patient been referred to a psychiatrist? (If yes, name)

7. Cardiac status (if related to disability)
a) Functional capacity Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)
b) Blood pressure (latest visit) Systol./Diastol.

8. Progress Recovered Improved Not improved Deteriorated Consolidation Y | M | D DAP %

9. Prognosis
a) Is patient now totally disabled?
b) If yes, when should patient be able to resume work?
c) If no, when was patient able to resume work?
d) If indefinite, give the estimated number of additional weeks/months before patient's return: Months Weeks Never

10. Rehabilitation
a) Can the patient participate in or benefit from a rehabilitation program? Yes -> Starting Y | M | D
b) If not, when and why?

Remarks \_\_\_\_\_

Physician's name (Print) \_\_\_\_\_ Address \_\_\_\_\_

Telephone no. \_\_\_\_\_ Signature \_\_\_\_\_ Date M.D. Y | M | D