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**APPLICATION FOR BENEFITS
 DISABILITY INSURANCE
 SHORT AND/OR LONG TERM
 Initial Application**

GROUP No.		EMPLOYER No.		IDENTIFICATION No.	
1		2		3	
Declaration by the insured person (Complete in block letters)					
4 FAMILY NAME			5 FIRST NAME		
6 ADDRESS No. STREET APT.		CITY		POSTAL CODE	
7 PHONE RESIDENCE () -		8 PHONE WORK () -		9 GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
				10 DATE OF BIRTH Y M D	

11 INCOME TAX STATUS Single <input type="checkbox"/> Single-parent <input type="checkbox"/> Married or de facto spouse <input type="checkbox"/>		DEPENDANTS Spouse: <input type="checkbox"/> No <input type="checkbox"/> Yes Children: <input type="checkbox"/> No <input type="checkbox"/> Yes → Number: ____	
12 Since you stopped working, have you exercised anyother occupation? <input type="checkbox"/> No <input type="checkbox"/> Yes → Starting date: Y M D		If so, specify the nature of the activities: _____	
13 Was the disability caused by an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe the circumstances, date and place.		_____	

14 Have you filed an application to benefit from a program or a plan mentioned below?	NO	YES			IF REFUSED	
		Under analysis	Accepted	Refused	Do you intend to challenge this decision? Yes No	
PROGRAM Employment insurance (HRDC) If accepted, beginning date for benefits: Y M D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commission de la santé et de la sécurité du travail (CSST)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compensation to victims of crime (CVCA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Société de l'assurance automobile du Québec (SAAQ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLAN Québec Pension Plan (QPP) or Canada Pension Plan (CPP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commission administrative de régimes de retraite et d'assurances (CARRA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private pension fund	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other group insurance policies: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: PLEASE INCLUDE A COPY OF ANY DOCUMENTS RECEIVED FROM THESE ORGANIZATIONS, INCLUDING THE BENEFIT PAYMENT NOTICE.

15 Declaration

"I hereby certify that the information here above is complete and true. I authorize the person in charge of the group insurance plan and La Capitale Insurance and Financial Services Inc. to use my social insurance number for administrative and/or identification purposes."

16 Autorization

"I authorize any physician, any other professional and participating party in the health care and rehabilitation sectors as well as any public or private health or social services institution, any insurance company, as well as any insurer, any public or private institution, any information officer who has received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any other person who has files or personal information, especially medical information to provide to La Capitale Insurance and Financial Services Inc. or to its mandataries, all information that he, she or it has, needed for the processing of my file.

I also authorize La Capitale Insurance and Financial Services Inc. to disclose this information to the persons indicated above whenever necessary, within the framework of their activities and the processing of my file.

In the event of death, I formally authorize the policyholder, employer, beneficiary, heir or liquidator of my succession, to provide to La Capitale Insurance and Financial Services Inc. or to its mandataries when required, all information or authorizations that make possible the processing of my file."

This consent is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value as the original.

Important

The following sections must be completed and signed:

- By the insured person**
 - declaration of the insured person
 - Upper section of the declaration completed by the attending physician
- By the employer**
 - declaration of the employer
- By the attending physician**
 - declaration of the attending physician

Signature of the insured person

 Y M D
 Date

1 Employer's name and address: _____

 Phone: () - _____ Ext.: _____
 Postal Code _____

2 Group No.: _____
 Employer No.: _____

3 Employee's family name: _____ 4 Employee's first name: _____

5 Employee's occupation: _____

6 Main duties performed by the employee: _____

7 Date of entry in your department: Y | | M | | D | |

8 Employee's identification number: | | | | | | | | | | | | | | | |

9 Monthly salary at the beginning of the disability: Gross: \$ _____

FEDERAL PROVINCIAL

10 Personal tax exemptions: \$ _____ \$ _____

11 Full time Part-time : % of part-time worked _____ On call Other (Specify): _____

12 Indicate the working days in an ordinary week: M T W T F S S Schedule: From _____ to _____
 Time Time

13 Number of hours worked in an ordinary week: _____

14 Last day at work: Y | | M | | D | | 15 Number of hours worked that day: _____

16 Date of first day of absence from work: Y | | M | | D | |

17 Has the employee returned to work? No Yes Date: Y | | M | | D | |

18 Is the disability due to: A workplace accident? An occupational disease?

19 If the employee is currently pregnant, has an application been made or will one be made to the CSST under the *Act respecting Occupational health and safety*?
 No Yes

20 Does the disability coincide with:

A dismissal? No Yes → Date: Y | | M | | D | |

A lay off? No Yes → from Y | | M | | D | | to Y | | M | | D | | Date: Y | | M | | D | |

The elimination of a workstation? No Yes → Date: Y | | M | | D | |

A Leave without pay? No Yes → from Y | | M | | D | | to Y | | M | | D | |

Other, please specify: _____ from Y | | M | | D | | to Y | | M | | D | |

21 During the disability period, have you paid any amounts to this employee? No Yes

	Nature	Period	Amount
If so, please explain the nature, the period and the amount: (Ex. : vacations, sick leave, employment insurance, etc.)	_____	_____	_____
	_____	_____	_____

22 If the employee is capable of performing work adapted to his or her condition, is it possible to reassign him or her to another position in your organization? No Yes

If so, please specify: _____

23 Are there any other details relevant to this application that we should know? No Yes

If so, please specify: _____

24 I hereby certify that the information here above is complete, accurate and true.

 Signature of the authorized person Date: Y | | M | | D | |

Physical Illnesses

Original request

Note: For psychological illnesses, complete the form on the reverse.

The insured must complete this section

1 Family name: _____ 2 First name: _____
 3 Contract No.: _____ 4 Social insurance number: _____
 5 Date of birth: _____

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____
 1.2 Secondary: _____
 1.3 Complications: _____
 1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:
 a) received medical treatments b) consulted another physician c) taken drugs d) been hospitalized e) undergone examinations
 Specify the periods: _____
 1.5 Is the disability related to: an accident an illness an occupational accident an automobile accident
 Date of the event: _____
 a pregnancy No Yes
 a preventive withdrawal from work No Yes Scheduled date of delivery: _____
 1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.
 At the beginning of disability _____ Currently _____

2. Treatment

2.1 Drugs - name - dosage: _____
 2.2 Has the patient undergone or will undergo:
 a) examinations or tests No Yes Specify: _____
 b) surgery No Yes Day surgery Type _____
 Surgical procedure: _____ Date: _____
 c) other treatments: No Yes Specify: _____
 d) hospitalization: from _____ to _____ Name of hospital: _____
 e) a short stay under observation: No Yes Number of hours: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: _____ Next consultation: _____
 3.2 Dates of other consultations: _____ Follow-up frequency: _____
 3.3 Referral to another physician: No Yes Name of physician: _____
 Specialty: _____
 3.4 Approximate duration of disability: No. of days _____ No. of weeks _____ Unspecified or date of return to work _____
 3.5 How long before the patient will be able to return to work? No. of days _____ No. of weeks _____
 part-time full-time gradual return Specify: _____

4. Questions specific to the contract

5. Identification of the physician

5.1 Family name, first name: _____ Telephone: _____
 5.2 License number: _____ Fax: _____
 General practitioner Specialist Specify: _____
 Signature: _____ Date: _____

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM

Psychological Illnesses

Original request

Note: For physical illnesses, complete the form on the reverse.

The insured must complete this section

1 Family name: _____ 2 First name: _____
 3 Contract No.: _____ 4 Social insurance number: _____
 5 Date of birth: _____

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____
 1.2 Secondary: _____
 1.3 Current symptoms: _____
 1.4 Degree of severity of all symptoms: Mild Moderate Severe With psychotic elements
 1.5 Does the interruption of work result from problems related to:
 marital/family life loss of employment or layoff professional problems
 personal or interpersonal problems alcohol or drug abuse or gambling problems
 other problems, specify: _____
 1.6 For the illnesses or associated symptoms diagnosed, has the patient previously:
 a) received medical treatments c) taken drugs e) undergone examinations
 b) consulted another physician d) been hospitalized
 Specify the dates of previous episodes: _____

2. Treatment

2.1 Drugs - name - dosage: _____
 2.2 Is the patient consulting: a psychiatrist? No Yes a social worker? No Yes
 a psychologist? No Yes another health care provider? No Yes
 If yes, name of the caregiver consulted: _____
 2.3 Hospitalization: from _____ to _____ Name of hospital: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: _____ Next consultation: _____
 3.2 Dates of other consultations: _____
 3.3 Follow-up frequency: _____
 3.4 Will the patient be referred to a psychiatrist? No Yes Name of physician: _____
 3.5 Approximate duration of disability: No. of days _____ No. of weeks _____ Unspecified or date of return to work _____
 3.6 How long before the patient will be able to return to work? No. of days _____ No. of weeks _____
 part-time full-time gradual return Specify: _____

4. Questions specific to the contract

5. Identification of the physician

5.1 Family name, first name: _____ Telephone: _____
 5.2 License number: _____ Fax: _____
 General practitioner Specialist Specify: _____
 Signature: _____ Date: _____

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM