

**Statement of insured**      The information requested in items 1 to 4 should also be entered on the upper part of the "Statement of Attending Physician".

1 Surname: \_\_\_\_\_ 2 Given name: \_\_\_\_\_

3 Contract no.: \_\_\_\_\_ 4 Social Insurance no.: \_\_\_\_\_  
group no. certificate no.

5 Mailing address: \_\_\_\_\_ Postal code: \_\_\_\_\_

6 Home telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

7 Sex: F  M  8 Date of birth:

| 9 CIVIL STATUS  | DEPENDENTS   |  |
|---|--|--|
| single <input type="checkbox"/> single-parent <input type="checkbox"/> married or common-law <input type="checkbox"/> | spouse: no <input type="checkbox"/> yes <input type="checkbox"/> | children: no <input type="checkbox"/> yes <input type="checkbox"/> number: → _____ |

10 Since you stopped working, have you had any other employment? no    yes    → Date of beginning:

If yes, specify the nature of the employment: \_\_\_\_\_

11 Is the disability the result of an accident? no    yes    → Describe the circumstances, including date and location.  
 \_\_\_\_\_

12 Have you already undergone a medical assessment related to your disability? no    yes

13 Have you applied for benefits under any of the following programs or plans?

| PROGRAM  | If yes, date payment of benefits began: <input type="text"/> | NO                       | IF YES                   |                          | IF REFUSED               |  |                          |
|--|---|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|
|  |   |                          | Under study              | Accepted                 | Refused                  | Do you intend to contest this decision?<br>yes      no |                          |
| Employment Insurance (EI)  |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Commission de la santé et de la sécurité du travail (CSST)               |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Compensation for victims of crime (CVC)                                  |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Société de l'assurance automobile du Québec (SAAQ)                       |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| <b>PLAN</b>  |   |                          |                          |                          |                          |  |                          |
| Québec Pension Plan (QPP) or Canada Pension Plan (CPP)                   |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Commission administrative de régimes de retraite et d'assurances (CARRA) |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Private pension plan   |   | <input type="checkbox"/>                               | <input type="checkbox"/> |
| Any other group insurance plan: _____                                    |   | <input type="checkbox"/>                               | <input type="checkbox"/> |

**NOTE: PLEASE INCLUDE COPIES OF ANY DOCUMENTS RECEIVED FROM THESE SOURCES, INCLUDING ANY BENEFIT PAYMENT STATEMENTS.**

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

For the purposes of reviewing my benefit claim, I authorize SSQ, Life Insurance Company Inc. (hereinafter SSQ) to obtain from corporate persons or individuals such as:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer, or the former employer;
- any other insurance or reinsurance companies;
- any public or parapublic organizations body, such as QPP or CPP, CSST, SAAQ, CARRA, EI;
- any other person or institution,

personal information on myself, namely medical information.

I hereby authorize the said corporate persons or individuals to disclose to SSQ the requested information and I release them of their liability to confidentiality.

I also authorize SSQ to communicate my file to one or several physicians of its choice for evaluation purposes.

Copies of this document shall have the same effect as the original.

**Important**

The following sections must be completed and signed:

- By the insured**
  - Statement of Insured (1 to 15)
- Upper part of Statement completed of Attending Physician**
- By the plan administrator**
  - Statement of Plan Administrator
- By the attending physician**
  - Statement of Attending Physician

14 \_\_\_\_\_ **Signature**      15           **Date**

**You can receive an email at each step of the processing of your disability file.**  
 Go to **SSQ.CA**, and register for the **ACCESS | Plan Members** Web site to automatically take advantage of this tool!  
 Don't forget to provide an email address that you'll have access to during your disability.

## Statement of plan administrator

1 Name of person responsible: \_\_\_\_\_ Title: \_\_\_\_\_

2 Name of group: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

3 Contract no.: \_\_\_\_\_  
group no. certificate no.

4 Surname of insured: \_\_\_\_\_ 5 Given name of insured: \_\_\_\_\_

6 Occupation of insured: \_\_\_\_\_

7 Description of insured's tasks: \_\_\_\_\_

8 Weekly salary at beginning of disability: Gross \$ \_\_\_\_\_ Net \$ \_\_\_\_\_ (gross salary less federal and provincial income taxes, QPP, and Employment Insurance)

9 Personal exemptions: Federal TD1 \$ \_\_\_\_\_ Provincial TP1015.3 \$ \_\_\_\_\_

10 Full-time  Part-time  : % of time worked \_\_\_\_\_ On call  Other  (specify): \_\_\_\_\_

11 Regular work week: from \_\_\_\_\_ day to \_\_\_\_\_ day workday: from \_\_\_\_\_ time to \_\_\_\_\_ time

12 Number of hours worked in a regular week: \_\_\_\_\_

13 Last day worked: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

 14 Number of hours worked on this day: \_\_\_\_\_

15 Date of first day of absence from work: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

16 Has the employee returned to work? no  yes  → Date: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

**17 TO BE COMPLETED FOR EMPLOYEES WITH VARIABLE WORK SCHEDULES**

Indicate in the appropriate boxes the number of hours for each day: 1<sup>st</sup> - As of the last day worked  
 2<sup>nd</sup> - On return to work

| year | month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |
|------|-------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
|      |       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|      |       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|      |       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |

18 Does the disability result from a work-related accident?  an occupational illness?

19 Does the disability coincide with:

a dismissal? no  yes  → Date: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

a lay-off? no  yes  → from 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

 to 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

 Date of notification: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

an elimination of a position? no  yes  → Date: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

an unpaid leave? no  yes  → from 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

 to 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

other: specify \_\_\_\_\_ from 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

 to 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

20 During the period of disability, have you made any payments to this employee? no  yes

**Nature**                      **Period**                      **Amount**

If yes, specify the nature, the period and the amount of any such payments:  
 (E.g.: holiday, sick-leave)

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

21 Is there any other information concerning the present claim that we should be aware of? no  yes

If yes, please specify: \_\_\_\_\_

22 If the employee is capable of performing a function with this condition, is there any work available in your organization? no  yes

If yes, please specify: \_\_\_\_\_

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

23 \_\_\_\_\_  
Signature of authorized person

24 Date: 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

1 Family name: \_\_\_\_\_ 2 Given name: \_\_\_\_\_  
 3 Contract no.: \_\_\_\_\_ 4 Social insurance number: \_\_\_\_\_  
Group or Contract no. Certificat no. 5 Date of birth: | Y | Y | Y | Y | M | M | D | D |

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

**1. Diagnostic**

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 and/or gambling problems  
 other problems, specify: \_\_\_\_\_

1.6 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 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:** \_\_\_\_\_

2.3 Hospitalization: from \_\_\_\_\_ to \_\_\_\_\_ Name of hospital: \_\_\_\_\_

**3. Follow-up and prognosis**

3.1 Date of first consultation for this disability: | Y | Y | Y | Y | M | M | D | D | Next consultation: | Y | Y | Y | Y | M | M | D | D |

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

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, given name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 5.2 License number: \_\_\_\_\_ Fax: \_\_\_\_\_  
 General practitioner  Specialist  Specify: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: | Y | Y | Y | Y | M | M | D | D |

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

1 Family name: \_\_\_\_\_ 2 Given name: \_\_\_\_\_  
 3 Contract no.: \_\_\_\_\_ 4 Social insurance number: \_\_\_\_\_  
Group or Contract no. Certificat no.  
 5 Date of birth: Y Y Y Y M M D D

**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: Y Y Y Y M M D D  
 a pregnancy No  Yes   
 a preventive withdrawal from work No  Yes  Scheduled date of delivery: Y Y Y Y M M D D  
 1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.  
 At the beginning of disability Y Y Y Y M M D D 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 \_\_\_\_\_ Date: Y Y Y Y M M D D  
 surgical procedure: \_\_\_\_\_  
 c) other treatments? No  Yes  Specify: \_\_\_\_\_  
 d) hospitalization: from \_\_\_\_\_ to \_\_\_\_\_ Name of hospital: \_\_\_\_\_  
 e) a short stay under observation (number of hours): \_\_\_\_\_

**3. Follow-up and prognosis**

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D  
 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 Y Y Y Y M M D D  
 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, given name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 5.2 License number: \_\_\_\_\_ Fax: \_\_\_\_\_  
 General practitioner  Specialist  Specify: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: Y Y Y Y M M D D

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