



11106

APPLICATION FOR AN EXTENSION OF SHORT AND/OR LONG TERM DISABILITY INSURANCE

This application must be completed by the insured or, if unable to do so personally, by some other person on his or her behalf. La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) reserves the right to require further information, if it so required. The company assumes no liability for any expenses pertaining to the producing of evidence for claims.

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
1	2	3
Declaration by the insured person (Fill in block letters)		
4 FAMILY NAME		5 FIRST NAME
6 ADDRESS No. STREET APT.		CITY POSTAL CODE
7 PHONE HOME () -	8 PHONE WORK () -	9 GENDER <input type="checkbox"/> M <input type="checkbox"/> F
		10 DATE OF BIRTH Y M D
11 EMPLOYER'S NAME:		12 PROFESSION/OCCUPATION:
13 Beginning of disability: Y M D		15 Are you still totally disabled? <input type="checkbox"/> No - date of end of disability: Y M D <input type="checkbox"/> Yes - without interruption since: Y M D
14 Last day at work: A M J		
16 Have you worked on a part-time basis since the beginning of your disability? <input type="checkbox"/> No <input type="checkbox"/> Yes How many days or hours per week? _____		17 a) Return to full-time work: Y M D b) Progressive return to work: Y M D
18 Since the last report, have you consulted a healthcare professional, received treatments or been examined? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, please provide details below. Hospitals, physicians consulted during your current disability: Name and address of the hospitals or physicians Date Treatment and/or operations		
19 What medication are you currently taking? _____		
20 Have you filed or do you intend to file an application for benefits with a public organization (QPP, CSST, CARRA) and/or an insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, with what organization? _____ Date of your application: Y M D <input type="checkbox"/> Accepted <input type="checkbox"/> Refused <input type="checkbox"/> Under analysis Other: Name of the insurance company _____ File Number _____ <input type="checkbox"/> Accepted <input type="checkbox"/> Refused <input type="checkbox"/> Under analysis		
21 Please provide any other information pertaining to this application that has not been provided in the preceding answers: _____		
22 I hereby declare that these answers are complete and true. _____ Signature of the insured person Date Y M D		

Physical Illnesses

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

Additional report

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 Objective elements of the physical examination and investigation (**attach copy** of recent results, X-rays, ECG, or other tests or examinations):

 Weight: _____ lb kg Height: _____ ft/in _____ m/cm Most recent blood pressure: _____
 1.4 Degree of the symptom's severity (M=mild, Md=moderate, S=severe)

	M	Md	S		M	Md	S
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Treatment

2.1 Drugs - name - dosage: _____
 2.2 Additional treatments (specify the type and frequency): _____
 2.3 Surgery (date, nature and procedure): _____
 2.4 Hospitalization: from _____ to _____ Name of hospital: _____
 2.5 Consultation with a specialist: No Yes → **Attach copy**

3. Follow-up and prognosis

3.1 Date of last consultation: _____ Next consultation: _____
 3.2 Tests and examinations to come: _____
 3.3 Frequency of follow-up: _____
 3.4 Referral to a specialist: No Yes Name of physician: _____
 3.5 Scheduled date of consultation with a specialist: _____ Specialty: _____
 3.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability	Currently

 3.7 Evolution: Progressive stable regressive
 3.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

 3.9 Patient's cooperation in the treatment: excellent average poor
 3.10 Would the patient benefit from assistance within the scope of a return to work? No Yes
 3.11 Approximate duration of disability: No. of days _____ No. of weeks _____ Unspecified or date of return to work _____
 3.12 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

Additional report

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 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity: (M = mild Md = moderate S = severe)

Signs	M	Md	S	Symptoms	M	Md	S
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Treatment

2.1 Drugs - name - dosage: _____

2.2 **Is the patient consulting:** Since when? **Is the patient treated in:** Specify:

a psychiatrist?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a treatment centre?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a psychologist?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a CLSC?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a social worker?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a day hospital?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
an other caregiver?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	group therapy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
				individual therapy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____

AXE II) Associated personality disorders? No Yes Specify: _____
Associated drug addiction, alcoholism or gambling problems? No Yes Specify: _____

AXE III) Associated illness: - diagnosis: _____
- drugs prescribed: _____

AXE IV) Associated psychosocial stress factors (in the last 12 months):

<input type="checkbox"/> personal or interpersonal problems	<input type="checkbox"/> loss of employment or layoff	<input type="checkbox"/> professional problems
<input type="checkbox"/> marital/family life	<input type="checkbox"/> alcohol or drug abuse or gambling problems	
<input type="checkbox"/> Other problems, specify: _____		

AXE V) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100 = perfect condition)
- at the beginning of treatment: _____ - currently: _____

3. Follow-up and prognosis

3.1 Date of last consultation: _____ Next consultation: _____
3.2 Follow-up frequency: _____
3.3 Will the patient be referred to a psychiatrist? No Yes Name of physician: _____
3.4 Patient's cooperation in the treatment: excellent average poor
3.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

3.6 Would your patient benefit from assistance within the scope of a return to work? No Yes
3.7 Do you consider that the patient's condition has improved in an optimal way? No Yes
3.8 Approximate duration of the disability: No. of days _____ No. of weeks _____ Unspecified or date of return to work _____
3.9 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