La Capitale

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com

Application for short and/or long term Disability Insurance Benefits

Initial Application

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
1	2	3

Insured's Declaration (Complete in block letters)

4 LAST NAME FIRST NAME

5 SIN (facultative)

6 ADDRESS NO. STREET APT.

TOWN/CITY

POSTAL CODE

7 HOME TEL.

8 WORK TEL.

9 SEX ☐ M ☐ F

10 DATE OF BIRTH Year Month Day

11 INCOME TAX STATUS

Single ☐ Single-parent ☐ Married or de facto spouse ☐

DEPENDANTS

Spouse: ☐ no ☐ yes Children: ☐ no ☐ yes → Number:

12 Since you stopped working, have you carried out another occupation? ☐ No ☐ Yes → Start date: Year Month Day

If yes, specify nature of activities:

13 Was your disability caused by an accident? ☐ No ☐ Yes → Describe circumstances, date and place.

FOR ANY DISABILITY CLAIM OVER 90 DAYS, please send us a copy of your entire medical file since your leave of absence, including test results and specialist reports, except for genetic testing.

14 Have you applied for or are you receiving any disability, wage loss or retirement benefits from a program or plan mentioned below?

	NO	IF YES			IF DECLINED	
		Pending	Approved	Declined	Contested decision? Yes	No
PROGRAM Employment Insurance (EI/HRDC) — If approved, start date of benefits: Year Month Day	☐	☐	☐	☐	☐	☐
Workers' Compensation or similar plan / *Commission des normes, de l'équité, de la santé et de la sécurité du travail* (WSIB/CNESST)	☐	☐	☐	☐	☐	☐
Compensation for Victims of Crime Act (CVCA)	☐	☐	☐	☐	☐	☐
Automobile Insurance Benefits / *Société de l'assurance automobile du Québec* (AB/SAAQ)	☐	☐	☐	☐	☐	☐
PLAN Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)	☐	☐	☐	☐	☐	☐
Commission administrative de régimes de retraite et d'assurances (CARRA)	☐	☐	☐	☐	☐	☐
Retraite Québec (RRQ) / Pension Plan	☐	☐	☐	☐	☐	☐
Any other disability benefits:	☐	☐	☐	☐	☐	☐

NOTE: PLEASE ENCLOSE A COPY OF ALL DOCUMENTS RECEIVED FROM THESE ORGANIZATIONS, INCLUDING ANY NOTICE OF PAYMENT OF BENEFITS

DIRECT DEPOSIT: To optimize the processing of your file, if you are eligible for disability benefits, La Capitale will make the payments directly in your bank account. To do so, please enclose a cheque specimen marked "Void".

15 **Declaration**
I hereby certify that the information provided below is true and complete.

16 **Authorization**
"I hereby 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 person who has files or personal information, especially medical information to provide to La Capitale or to its agents, subsidiaries, affiliates, third party administrators and reinsurers, all information that he, she or it has, for the following purposes: to investigate and confirm the accuracy of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

I also authorize La Capitale 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 or to its mandataries when required, all information or authorizations that make possible the processing of my file.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting. I authorize La Capitale to pay the benefits directly into the account which bears the number appearing on the attached cheque."

This authorization is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy or electronic copy of this authorization shall be as valid as the original.

Signature of Insured

Year Month Day
Date

Important

The following sections must be completed and signed:

By the insured

- Insured's Declaration
- Upper section of the declaration completed by the attending physician

By the employer

- Employer's Declaration

By the attending physician

- Attending Physician's Declaration

La Capitale

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com

Employer's or Policyholder's Declaration

1. Name and address of employer: ____________________ Postal Code

   Tel.: ____________ Ext.: ______

2. Group No.: ______

   Employer No.: ______

   Identification No.: ______

3. Employee's last name: ____________________

4. Employee's first name: ____________________

5. Employee's occupation: ____________________

6. Employee's main duties: ____________________

7. Employment start date: Year / Month / Day

8. Social Insurance Number (If taxable Benefit): ______

9. Employee's Identification No.: ______

10. Monthly salary at the start of disability: Gross: $ ______

11. Personal tax exemptions: FEDERAL $ ______ PROVINCIAL $ ______

12. Full time ☐ Part time ☐ % of part time worked ______

    On call ☐ Contract ☐: Date of the end of the contract: Year / Month / Day Other ☐: (Specify): ______

13. Indicate the working days in an ordinary week: M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S ☐ Schedule: From ______ (Time) to ______ (Time)

14. Number of hours worked in an ordinary week: ______

15. Last day at work: Year / Month / Day

16. Number of hours worked that day: ______

17. Date of first day of absence from work: Year / Month / Day

18. Has the employee returned to work? No ☐ Yes ☐ Date: Year / Month / Day

19. Is the disability due to: A workplace accident? ☐ An occupational disease? ☐

20. 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 ☐

21. Does the disability coincide with:

    A dismissal? No ☐ Yes ☐ → Date: Year / Month / Day

    A lay off? No ☐ Yes ☐ → from Year / Month / Day to Year / Month / Day Date notice given: Year / Month / Day

    The elimination of a workstation? No ☐ Yes ☐ → Date: Year / Month / Day

    A leave without pay? No ☐ Yes ☐ → from Year / Month / Day to Year / Month / Day

    Other, please specify: ______ from Year / Month / Day to Year / Month / Day

22. During the period of disability, have you paid any amounts to this employee? No ☐ Yes ☐

    If yes, please specifiy the nature, period and amount: (e.g. vacation, sick pay, employment insurance, etc.)

Nature	Period	Amount

23. If the employee is able to perform work adapted to his or her condition, would it to be possible to reassign him or her to another position in your organization? No ☐ Yes ☐

    If yes, please specify: ______

24. Is there any other information relevant to this application that we should be aware of? No ☐ Yes ☐

    If yes, please specify: ______

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

Signature of Authorized Representative ______ Date: Year / Month / Day

La Capitale
La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PHYSICAL ILLNESSES

Section to be completed by the Insured

Note: For psychological illnesses, complete the reverse of this form.

1. Last Name:
2. First Name:
3. Group No. / Identification No.:
4. SIN (facultative):
5. Date of Birth: Year Month Day

Attending Physician's Declaration (Complete in block letters and give to the patient)

FOR ANY DISABILITY CLAIM OVER 90 DAYS, please send us a copy of the entire medical file of your patient since the leave of absence, including test results and specialist reports, except for genetic testing.

1. Diagnosis

1.1 Primary:

1.2 Secondary:

1.3 Complications:

1.4 For the illnesses or related symptoms diagnosed, has the patient previously:

a) received medical treatment ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify periods:

1.5 Please specify whether the incapacity is related to: An accident ☐ An illness ☐ An occupational accident ☐ An automobile accident ☐

Date of the event: Year Month Day

Pregnancy No ☐ Yes ☐

A preventive withdrawal from work No ☐ Yes ☐ Expected date of delivery: Year Month Day

1.6 Describe the functional limitations preventing the patient from carrying out his or her professional duties or usual activities.

At the start of disability Year Month Day

Currently

2. Treatment

2.1 Drugs – name – dosage:

2.2 Specify if the patient has undergone or will undergo:

a) Examinations or tests No ☐ Yes ☐ Specify:

b) An operation No ☐ Yes ☐ Day surgery ☐ Type

Surgical procedure: ↳ Date: Year Month Day

c) Other treatments: No ☐ Yes ☐ Specify:

d) Hospitalization: from to Name of hospital:

e) A short stay under observation: No ☐ Yes ☐ (No. of hours):

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Year Month Day Next consultation: Year Month Day

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 Indefinite ☐ or Date of return to work Year Month Day

3.5 How long before the patient is likely to be able to return to work? No. of days No. of weeks

Part time ☐ Full time ☐ Gradual return ☐ Specify:

4. Contract-specific questions

5. Identification of physician

5.1 Last name, first name: Tel.:

5.2 License No.: Fax:

General practitioner ☐ Specialist ☐ Specify:

Signature: Date: Year Month Day

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PSYCHOLOGICAL ILLNESSES

Section to be completed by the Insured

Note: For physical illnesses, complete the reverse of this form

1. Last Name: ______
2. First Name: ______
3. Group No. / Identification No.: ______
4. SIN (facultative): ______
5. Date of Birth: Year ______ Month ______ Day ______

Attending Physician's Declaration (Complete in block letters and give to the patient)

FOR ANY DISABILITY CLAIM OVER 90 DAYS, please send us a copy of the entire medical file of your patient since the leave of absence, including test results and specialist reports, except for genetic testing.

1. Diagnosis

1.1 Primary: ______

1.2 Secondary: ______

1.3 Current symptoms: ______

1.4 Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe ☐ With psychotic elements ☐

1.5 Describe the functional limitations preventing the patient from carrying out his or her professional duties or usual activities.

At the start of disability	Currently

1.6 Specify whether the patient's absence from work is due to problems related to:

- ☐ Marital/family life
- ☐ Loss of employment or layoff
- ☐ Occupational problems
- ☐ Personal or interpersonal problems
- ☐ Alcohol or drug abuse and/or gambling problems
- ☐ Other, specify: ______

1.7 For the illnesses or related symptoms diagnosed, has the patient previously:

a) received medical treatment ☐
b) consulted another physician ☐
c) taken drugs ☐
d) been hospitalized ☐
e) undergone examinations ☐

Please specify dates of any previous episodes: ______

2. Treatment

2.1 Drugs – name – dosage: ______

2.2 Specify whether the patient is consulting:

A psychiatrist	No ☐	Yes ☐
A psychologist	No ☐	Yes ☐
A social worker	No ☐	Yes ☐
Another health care provider	No ☐	Yes ☐

If yes, name of service provider: ______

2.3 Hospitalization: from ______ to ______ Name of hospital: ______

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Year ______ Month ______ Day ______ Next consultation: Year ______ Month ______ Day ______

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 ______ Indefinite ☐ or Date of return to work Year ______ Month ______ Day ______

3.6 How long before the patient is likely to be able to return to work? No. of days ______ No. of weeks ______

Part time ☐ Full time ☐ Gradual return ☐ Specify: ______

4. Contract-specific questions

______

5. Identification of physician

5.1 Last name, first name: ______ Tel.: ______

5.2 License No.: ______ Fax: ______

General practitioner ☐ Specialist ☐ Specify: ______

Signature: ______ Date: Year ______ Month ______ Day ______

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.