La Capitale

Application for extension long term Disability Insurance

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

This form must be completed by the insured or, if unable to do so personally, by another person on the insured's behalf. La Capitale Civil Service Insurer Inc. (hereinafter La Capitale) reserves the right to require any additional information it deems necessary. The company assumes no liability for any expenses incurred in providing the proof required for claims.

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

1. INFORMATION ABOUT THE INSURED

Group No.	Employer No.	Identification No.	Date of birth (Year / Month / Day)

Last name	First name	Gender
		☐ M ☐ F

No., street	City

Province	Postal code	Telephone (home)	Telephone (work/cell.)

A If you returned to work, date of return: Year Month Day How many days or hours per week? _____

B Since the last report, have you consulted a health professional, received treatments or undergone any examinations? ☐ No ☐ Yes

If so, please provide details below.

Hospitals and physicians consulted during your current disability:

Name and address of hospital or physician	Date	Treatments/operations

C What medication are you currently taking? _____

D Have you applied or do you plan to apply for any disability, wage loss or retirement benefits with a government body? ☐ No ☐ Yes

If so, which organization? _____ Date of application: Year Month Day ☐ Approved ☐ Declined ☐ Under assessment

2. DECLARATION AND AUTHORIZATION

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

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."

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.

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 attending physician
- **Attending Physician's Declaration**

Signed at _____ on this _____ day of _____ 20 _____.

X _____
Signature of Insured

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Supplementary Report

PHYSICAL ILLNESSES

Section to be completed by the insured

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

1. Last Name: _____ 2. First Name: _____
3. Group No. / Identification No.: _____ 4. Date of Birth: Year / Month / Day

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

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

1. Diagnosis

1.1 Primary:

1.2 Secondary:

1.3 Objective elements of 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 severity of symptoms (M=mild, Md=moderate, S=severe)

	M	Md	S		M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage:

2.2 Additional treatments (specify 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 ☐ → **If so, attach copy of report**

3. Follow-up and prognosis

3.1 Date of last consultation: Year / Month / Day Next consultation: Year / Month / Day

3.2 Tests and examinations to come, specify:

3.3 Frequency of follow-up:

3.4 Referral to a specialist: No ☐ Yes ☐ **If so,** name of physician: _____

3.5 Scheduled date of consultation with a specialist: Year / Month / Day Specialty: _____

3.6 Describe the functional limitations preventing the patient from carrying out her professional duties or usual tasks.

At the start of disability	Currently

3.7 Evolution: Progressive ☐ Stable ☐ Regressive ☐

3.8 If you anticipate that this absence from work will extend beyond the usual period for such a diagnosis, please explain the factors justifying your prognosis.

3.9 Patient's cooperation in treatment: Excellent ☐ Average ☐ Poor ☐

3.10 Approximate duration of disability: No. of days _____ No. of weeks _____ Indefinite ☐ or date of return to work Year / Month / Day

3.11 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. Other comments

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.

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Supplementary Report

PSYCHOLOGICAL ILLNESSES

Note: For physical illnesses, complete the previous page of this form.

Section to be completed by the insured

1 Last Name: _____ 2 First Name: _____

3 Group No. / Identification No.: _____ 4 Date of Birth: Year ____ Month ____ Day ____

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

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

1. Diagnosis

1.1 Primary: _____

1.2 Secondary: _____

1.3 Please describe signs and symptoms and indicate the frequency and degree of severity of each: (M = Mild Md = Moderate S = Severe)

Signs	M	Md	S	Symptoms	M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

1.4 Describe the functional limitations preventing the patient from carrying out her professional duties or usual tasks.

At the start of disability	Currently

2. Treatment

2.1 Drugs – name – dosage: _____

2.2

Specify whether the patient is consulting a:			If so, since when?	Treatment provided by/in:			If so, specify:
Psychiatrist	No ☐	Yes ☐		Treatment centre	No ☐	Yes ☐	
Psychologist	No ☐	Yes ☐		CLSC	No ☐	Yes ☐	
Social worker	No ☐	Yes ☐		Day hospital	No ☐	Yes ☐	
Other health professional	No ☐	Yes ☐		Group therapy	No ☐	Yes ☐	
				Individual therapy	No ☐	Yes ☐	

AXIS II) Associated personality disorders? No ☐ Yes ☐ If so, specify: _____

Associated drug addiction, alcoholism or gambling problems? No ☐ Yes ☐ If so, specify: _____

AXIS III) Associated illness: – Diagnosis: _____

– Drugs prescribed: _____

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

☐ Personal or interpersonal problems ☐ Loss of employment or layoff ☐ Occupational problems

☐ Marital or family problems ☐ Alcohol or drug abuse or gambling problems or both

☐ Other, specify: _____

AXIS V) General functioning scale (according to DSM-IV GFS scale (0 to 100) 100 = perfect condition) → At start of treatment: _____ Currently: _____

3. Follow-up and prognosis

3.1 Date of last consultation: Year ____ Month ____ Day ____ Next consultation: Year ____ Month ____ Day ____

3.2 Follow-up frequency: _____

3.3 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ If so, specify name of physician: _____

3.4 Patient's cooperation in treatment: Excellent ☐ Average ☐ Poor ☐

3.5 If you anticipate that this absence from work will extend beyond the usual period for such a diagnosis, please explain the factors justifying your prognosis.

3.6 Do you consider that the patient's condition has improved in an optimal way? No ☐ Yes ☐

3.7 Approximate duration of disability: No. of days _____ No. of weeks _____ Indefinite ☐ or Date of return to work Year ____ Month ____ Day ____

3.8 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. Other comments

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.