La Capitale

La Capitale Civil Service Insurer Inc.
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Initial Application for long term Disability Insurance Benefits

Employer's Declaration

INFORMATION ABOUT THE INSURED

Last name	First name

Group No.	Employer No.	Identification No.

EMPLOYER'S DECLARATION

1. **Name and address of employer:** ____________________

   ____________________ **Postal Code**

   Tel.: ____________ **Ext.:** ______

2. **Employee's occupation:** ____________________

3. **Employee's main duties:** ____________________

   ____

4. **Employment start date:** Year Month Day

5. **Monthly gross salary at the start of disability: $** ____________

6. ☐ **Full time** ☐ **Part time – % of part time worked:** ________

   ☐ **On call** ☐ **Other (specify):** ____________

7. **Average working hours per week:** ________

8. **Has the employee returned to work?** ☐ No ☐ Yes – **If so,** date: Year Month Day

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

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

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

    If so, specify: ____________________

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

Signed at ____________________ on this ________ day of ____________________ 20 ______ .

____
Signature of Insured

Please complete, sign and date the *Additional information* section on the next page.

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ADDITIONAL INFORMATION

1. a) Date of last day worked: Year | Month | Day

   b) Date of first day of absence from work: Year | Month | Day

   c) Date of first day paid income insurance from the employer's plan: Year | Month | Day

   d) Termination date of short-term disability insurance benefits (104 weeks + 5 working days [FT] or 7 calendar days [PT]): Year | Month | Day

2. Gross annual salary at the end of the 104th week of benefits equal to 80% of pre-disability income: $ ____

   If part time – % of time worked: ____ %

3. Please specify the following amounts, which demonstrate calculation of the **net benefit** received from the employer for the 104th week of benefits:

Gross weekly benefit:		$ ____
Federal tax statement:	–	$ ____
Provincial tax statement:	–	$ ____
RRQ:	–	$ ____
EI:	–	$ ____
QPIP:	–	$ ____
Net benefit:	=	**$** ____

4. Benefit paid by: ☐ CNESST ☐ IVAC ☐ SAAQ ☐ Retraite Québec

   a) Start date of benefits: Year | Month | Day   b) End date of benefits: Year | Month | Day

5. The employee is involved in:

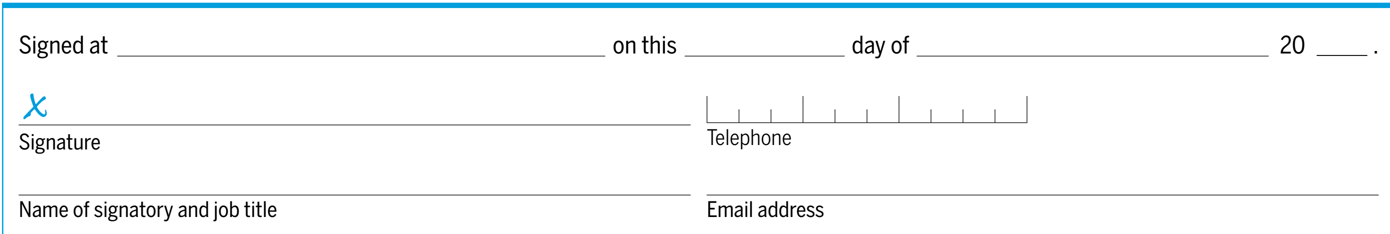
   a) A part-time return to work: ☐ No ☐ Yes – Since: Year | Month | Day

   b) Phased retirement: ☐ No ☐ Yes – Since: Year | Month | Day

   c) A deferred pay plan: ☐ No ☐ Yes – Since: Year | Month | Day

6. Pension plan to which the employee belongs: ____

7. Please send us a copy of a detailed description of the employee's duties. Our contact information is provided in the cover letter for this form.



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

X ____
Signature

Telephone

Name of signatory and job title

Email address