La Capitale

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St., PO Box 16040
Quebec QC G1K 7X8

DECLARATION OF THE INSURED PERSON

Long term disability

Initial application

This form is to be completed by the insured or by someone else on his or her behalf, if he or she is unable to complete it alone. The Insurer reserves the right to require additional information it deems necessary. The Insurer assumes no liability for any fees for providing proof relating to this claim.

Declaration of the insured person (Complete in block letters)

Name

Address

Postal Code

Telephone: Home Work

Name of employer:

Gender ☐ F ☐ M

Date of birth Year Month Day

Occupation:

Telephone:

1. Last day worked: Year Month Day
2. Date disability began: Year Month Day
3. Are you still totally disabled?
   ☐ No – date disability ended: Year Month Day
   ☐ Yes – continuously since: Year Month Day
4. Have you worked part time since the beginning of your disability?
   ☐ No ☐ Yes **If so**, how many days or hours/week?
5. a) Return to work on a full-time basis: Year Month Day
   b) Gradual return to work: Year Month Day
6. Is your disability due to an accident? ☐ No ☐ Yes **If so**, describe the circumstances of the accident.
7. If your disability is due to an illness, have you ever suffered from the same or a similar illness? ☐ No ☐ Yes **If so**, please give details and date.
8. Nature of current disability:
9. What medication are you currently taking?
10. a) Physicians consulted during current disability:

Name and address of physicians	Date	Treatment/surgery
	Year Month Day	
	Year Month Day	
	Year Month Day	

b) In which hospitals did you receive treatment for this disability?

Name and address of hospitals

From Year Month Day To Year Month Day

From Year Month Day To Year Month Day

From Year Month Day To Year Month Day

11. Do you use tobacco products? ☐ No ☐ Yes **If so**, please indicate amount per day: How long have you used tobacco? Year Month

If no, did you previously use tobacco products? ☐ No ☐ Yes **If so**, on what date did you quit? Year Month

12. Have you applied or do you plan to apply for benefits with a government body (CARRA, workers' compensation, QPP or CPP, automobile insurance board) and/or another insurance company? ☐ No ☐ Yes

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

Other: Name of insurance company File No. ☐ Approved ☐ Declined ☐ Under assessment

Please provide any other information relating to this claim that has not been provided in the answers above:

I hereby declare that all answers are true and complete.

Date Signature of the insured person

Please submit a copy of your birth certificate if you have not already done so.