INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.
www.inalco.com

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Quebec City, QC G1K 7M3
Telephone: 418 684-5232

DISABILITY
CLAIMANT'S STATEMENT

The patient is responsible for any charges made for completing this form.

❑ Waiver of premiums
❑ Premium waiver and total disability income
❑ Complementary income
❑ Anticipated benefit
❑ Disability insurance
❑ Loss of sight or limb(s)
❑ CID
❑ Home Protection Plan
❑ Momentum

Claim no.:

❑ **New file**

Agent | Agency | Code | S.U.

1. Contract numbers

2. Insured's last name

3. First name(s) | Date of birth Y M D

4. No. | **5.** Street | **6.** Apt.

7. City | **8.** Province | **9.** Postal code

10. Phone no. (home) | **11.** Social Insurance Number

12. Occupation at time of disability | **13.** Gross monthly income $

14a. Name of employer | **15a.** Are you still employed there? ❑ Yes ❑ No

14b. Address of employer | **15b.** If not, since when? Y M D

16. Date you stopped working for medical reasons

17. Are you still completely unable to work? ❑ Yes ❑ No ⇨ Since

18. Have you returned to work part-time?
Your duties ❑ Yes ❑ No
Any other duties ❑ Yes ❑ No
Yes ⇨ From__________________________ To__________________________

19. Have you resumed working completely? ❑ Yes ⇨ Since ❑ No

20a. Have you returned to school? ❑ Yes ⇨ Since ❑ No

20b. What kind of courses are you taking? Number of hours per week

21. Details of accident or nature of illness (If accident, how did it occur?)

22. Date of accident or beginning of illness

23. Have you ever had the same or a similar illness before? ❑ Yes ⇨ State when ❑ No

24. Name of attending physician

25. Address of attending physician

26. Name of hospital

27. Address of hospital

28. Hospitalization dates

29. Have you made a claim or intend to submit a claim to a government agency?
❑ No
❑ Yes ⇨ Which one? ❑ CSST ❑ SAAQ ❑ WCB ❑ Régie des rentes du Québec ❑ Canada Pension Plan ❑ Other: ____________________________

N.B. Enclose copy of letter of acceptance and copy of the last cheque stub received

Amount: $

30. Name of any other company with which you have filed or intend to file a claim for this disability

❑ Individual policy
❑ Group insurance
❑ Mortgage disability insurance

N.B. Enclose copy of letter of acceptance and copy of the last cheque stub received

Monthly income $ | $

I certify that the answers given above are complete and true.

Signed at ____ **Date** Y M D

______________________ **Witness**   ______________________ **Insured**

F35-55A (06-04)

PLEASE DO NOT DETACH THE AUTHORIZATION

AUTHORIZATION

I hereby authorize any healthcare professional, public or private health organization or any other public or private organization holding information concerning me, to supply this information to **Industrial Alliance Insurance and Financial Services Inc.** or its authorized agent for the assessment of my claim. A photocopy of this authorization shall be as valid as the original.

Signed at____ **Date** Y M D

______________________ **Witness**   ______________________ **Insured**

Address ______________________ Postal code   Address ______________________ Postal code

Telephone   Telephone

The patient is responsible for any charges made for completing this form. **ATTENDING PHYSICIAN'S STATEMENT**

Patient's name

Date of birth Y M D

1. Previous medical history

a) Symptoms first appeared or accident happened on Y M D

b) Date total disability began Y M D

c) Has patient already had same or similar condition?

❑ Yes ⇨ If yes, state when and describe ____________ Date Y M D

❑ No ❑ Unknown

d) Is condition due to injury or sickness arising from patient's employment? ❑ Yes ❑ No ❑ Unknown

e) If condition is due to pregnancy, what is (or was) the expected date of delivery? Y M D

f) If **relapse**, date total disability reoccurred: Y M D

g) Name of other attending physicians

2. Diagnosis of present condition

a) Primary ____________

b) Secondary (if applicable) ____________

c) Results of current X-rays, E.K.G. or any other special tests ____________

d) Describe the conditions that currently prevent the patient from returning to his/her occupation. Are they ❑ temporary? ❑ permanent?

____

e) Additional conditions which might affect the duration of disability ____________

3. Treatment

a) Date of first visit for present period of disability Y M D

b) Date of last visit Y M D

c) Frequency of visits ❑ Weekly ❑ Monthly ❑ Other (specify) ____________

d) Is patient following recommended treatment program? ❑ Yes ❑ No

e) Nature and duration of treatment ____________

4. Hospitalization

a) Name of hospital ____________

b) Hospitalized from Y M D to Y M D

c) If surgery performed, describe: ____________ Date Y M D

5. Physical incapacities

a) Is patient: ❑ Ambulatory? ❑ House confined? ❑ Bedridden? ❑ Hospitalized?

b) If ambulatory or house confined, please complete the section below

❑ No restriction; capable of all physical activities

❑ Moderate restriction; normal duties with moderate effort

❑ Marked restriction; light duties

❑ Complete restriction; total incapacity

6. Nervous or psychiatric disorders

a) What are the subjective and objective symptoms observed? ____________

b) What are the psychosocial stressors? ____________

c) Has the patient been referred to a psychiatrist? (If yes, name) ____________

7. Cardiac status (if related to disability)

a) Functional capacity

❑ Class 1 (no limitation)

❑ Class 2 (slight limitation)

❑ Class 3 (marked limitation)

❑ Class 4 (complete limitation)

b) Blood pressure (latest visit)____________Systol./Diastol.

8. Progress

❑ Recovered ❑ Improved ❑ Not improved ❑ Deteriorated ❑ Consolidation Y M D DAP____________%

9. Prognosis

	For regular occupation?	For any other occupation?
a) Is patient now totally disabled:	❑ Yes ❑ No	❑ Yes ❑ No
b) If yes, when should patient be able to resume work?	Y M D	Y M D
c) If no, when was patient able to resume work?		
d) If indefinite, give the estimated number of additional weeks/months before patient's return:	____ Months ____ Weeks ❑ Never	____ Months ____ Weeks ❑ Never

10. Rehabilitation

a) Can the patient participate in or benefit from a rehabilitation program? ❑ Yes ⇨ Starting Y M D

b) If not, when and why? ____________

Remarks

Physician's name (Print)

Address

Telephone no.

Signature

M.D.

Date Y M D

The patient is responsible for any charges incurred for completing this form.