HUMANIA ASSURANCE

GROUP INSURANCE

DISABILITY CLAIM FORM

Initial assessment

HUMANIA ASSURANCE

Group insurance
Disability claim form – Initial assessment

In order to ensure confidentiality of personal information, Humania Assurance will establish a claim file in which information concerning all of your claims will be kept. Only employees or authorized agents of Humania Assurance responsible for the management of your claim shall have access to the file.

Instructions for:

A. The claimant

1. Please complete and sign the "Claimant statement" section.
2. Please ensure that the policyholder completes and signs the "Policyholder statement" section.
3. Please ensure that your physician completes and signs the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other condition. As well, please provide your physician with a copy of your completed "Claimant statement" so that the physician will have your signed authorization to release information to Humania Assurance.
4. Please note that any costs incurred for the completion of the "Attending physician statement" are your responsibility.
5. Please ensure that all of the above-mentioned forms are submitted to Humania Assurance on a timely basis. Submitting them together will avoid unnecessary delays in the assessment of your claim. Also, please enclose a copy of the first and/or last unemployment cheque stub and the record of employment form if applicable.

Direct deposit

6. Please complete and sign the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Humania Assurance. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

B. The policyholder

1. Please complete and sign the "Policyholder statement" section.
2. In order to avoid unnecessary delays in the processing of Long-Term Disability claims (without Short-Term Disability), we ask that these forms be completed and sent to Humania Assurance as follows:

   For policies with an elimination period of:

   - 15 weeks, completed forms should be sent to us as of the 8th week of absence;
   - 17 weeks, completed forms should be sent to us as of the 11th week of absence;
   - 26 weeks, completed forms should be sent to us as of the 20th week of absence.

C. The physician

1. Please complete and sign the appropriate "Attending physician statement", depending on the nature of the primary diagnosis.

Direct deposit – Authorization

❑ Initial request for direct deposit ❑ Request for bank account change ❑ Request to end direct deposit

I Insured statement (please print)

Policy and sub-group no.	Certificate no.	Insured surname	Given name(s)

Telephone no. (day)	Main residence address (no., street)	Apt.

City	Province	Postal code

Financial institution name	Financial institution address

II Type of bank account (please print)

❑ Chequing ❑ Savings Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

Branch no. (5 digit number)	Institution no. (3 – 4 digit number)	Account no. (All numbers)

III Authorization

I authorize Humania Assurance to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Humania Assurance of any subsequent changes. I accept that this agreement may be cancelled at any time by either Humania Assurance, myself, in writing or verbally.

Insured signature	Date (YYYY/MM/DD)

Account holder signature (if other than Insured)	Date (YYYY/MM/DD)

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Our address is: P.O. Box 10 000 at Saint-Hyacinthe (Quebec) J2S 7C8 • Web site: www.humania.ca

Claimant statement

To be completed by the claimant. All questions must be answered in as much detail as possible.

Section A – General information

❑ Mr. ❑ Mrs. ❑ Ms.	Gender ❑ Male ❑ Female	Date of birth (YYYY/MM/DD)	Policy no.	Certificate no.
Surname	Given name(s)	Social insurance number		
Address (no., street)				
City	Province	Postal code	Telephone no.	Language ❑ Fr. ❑ En.
Name of employer *(and division if different)*	Occupation *(just prior to last day worked)*	Original date of hire (YYYY/MM/DD)		
Other current employer ❑ Yes ❑ No If yes, please name.				
Nature of request for benefits ❑ Short-Term Disability (Please enclose a copy of the record of employment form, if applicable) ❑ Long-Term Disability ❑ Waiver of premiums				

Section B – Claim information

Was the reason you stopped working due to
❑ Illness ❑ Injury away from work ❑ Motor vehicle accident (not while working) ❑ Occupational illness or work accident
(If the reason was a motor vehicle accident, please submit a police or collision report, except in Quebec.)

If you have suffered an injury, please describe how, when, and where the injury occurred.

Last day worked (YYYY/MM/DD)

Were you performing ❑ Your regular duties ❑ Modified duties

Was this a full day? ❑ Yes ❑ No	If no, how many hours did you work on your last day?
Date you were first unable to work (YYYY/MM/DD)	When did you first notice these symptoms? (YYYY/MM/DD)

When were you first treated by a physician for this condition? (YYYY/MM/DD)

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? ❑ Yes ❑ No If yes, please provide the dates and name(s) of physicians who treated you at the time.

Please describe the major duties of your occupation.

Please describe why you are unable to perform the duties of your occupation.

Please indicate if you are ❑ Right-handed ❑ Left-handed

Do you have an expected date of return to work? ❑ If yes, please provide the date (YYYY/MM/DD) ❑ No

Claimant statement (continued)

Section C – Health care professionals information

Please list all of the health care professionals you have consulted **in the last 12 months,** starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name	Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)		
Telephone no.	Fax no.	Specialty
Name	Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)		
Telephone no.	Fax no.	Specialty
Name	Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)		
Telephone no.	Fax no.	Specialty

Section D – Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the appropriate section below and submit a copy of your notice of acceptance or refusal, if applicable.

Source	Claim no., contact name, telephone no.	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Are you receiving payment? Pending	Monthly Amount
Worker's Comp – CSST, WSIB, WCB		❑	❑	❑	❑	❑	
Crime victims compensation (IVAC)		❑	❑	❑	❑	❑	
Canada Pension Plan – Disability		❑	❑	❑	❑	❑	
Canada Pension Plan – Retirement		❑	❑	❑	❑	❑	
Quebec Pension Plan (QPP) – Disability		❑	❑	❑	❑	❑	
Quebec Pension Plan (QPP) – Retirement		❑	❑	❑	❑	❑	
Employment Insurance		❑	❑	❑	❑	❑	
Provincial auto insurance – SAAQ		❑	❑	❑	❑	❑	
Other insurer		❑	❑	❑	❑	❑	

Section E – Claimant authorization and declaration

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance, all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance Inc., to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance, will use the information provided in this form and any prior claims under the same plan for the management of my claim and for production of statistical reports.

I certify that the information contained in this form is true and complete.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

Name (please print) _____ Signature _____

Policy no. _____ Date (YYYY/MM/DD) _____

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Policyholder statement

To be completed by the policyholder. All questions must be answered in as much detail as possible.

Section A – Policyholder information

Name of policyholder (Employer/Union/Association)	Name of subsidiary or division (if different)
Address (no., street)	

City	Province	Postal code	Telephone no.

Section B – Claimant information

Surname	Given name(s)

Policy no.	Division no.	Class no.	Social insurance number	Certificate no.	Permanent employee? ❑ Yes ❑ No

Nature of request for benefits
❑ Short-Term Disability (please enclose a copy of the record of employment form, if applicable)
❑ Long-Term Disability ❑ Waiver of premiums

Please provide the date on which this claimant was first covered under this policy. (YYYY/MM/DD)

Was the employee actively at work when the absence began/loss occured? ❑ Yes ❑ No If no, please comment.

What was the claimant's date of hire? (YYYY/MM/DD)	Last date of work? (YYYY/MM/DD)	Forseen return to work date? (YYYY/MM/DD)

If already back at work, what was the start date? (YYYY/MM/DD)
❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual – Please provide the return to work protocol

What was the claimant's main reason for the absence?
❑ Illness ❑ Injury away from work ❑ Motor vehicle accident (not while working) ❑ Occupationnal illness or work related accident

Please indicate the hours of work in a normal work week.

Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____
(If shift work, please provide work schedule.)

What was the claimant's gross weekly salary as of his/her last day of work? $_____

Was the claimant ❑ Salaried ❑ Hourly ❑ On call

Did the claimant receive any income during the disability period? ❑ Yes ❑ No
If yes, please select one of the following: ❑ Vacation ❑ Maternity leave ❑ Sick days
❑ Employment insurance (please enclose a copy of the record of employment form) ❑ Statutory holidays ❑ Other _____

Amount $_____ From _____ (YYYY/MM/DD) _____ to _____ (YYYY/MM/DD) _____

Has the claimant submitted a claim to the following government bodies?
❑ WSIB/WCB/CSST ❑ Employment insurance (Please enclose a copy of the record of employment form) ❑ CPP ❑ QPP (RRQ)
❑ SAAQ – Provincial automobile insurance board ❑ Crime Victim Compensation Act

Policyholder statement (continued)

Section C – Occupational information

What was the claimant's regular occupation immediately prior to his/her stopping work?

Were the claimant's duties modified from his/her regular occupation? ❑ Yes ❑ No

Please describe this employee's regular occupation (or attach a copy of the job description) as well as any modifications.

The following physical demands analysis of the claimant's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

I) at any one time without a break (approximately) and;
II) in total throughout the day (approximately)

Physical demands analysis

		I	II
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down the stairs			
6. Lifting	0 – 10 pounds ❑ 10 – 20 pounds ❑ 20 – 50 pounds ❑ 50 pounds + ❑ with lifting device? Yes ❑ No ❑		
7. Pushing/Pulling	0 – 10 pounds ❑ 10 – 20 pounds ❑ 20 – 50 pounds ❑ 50 pounds + ❑		

Please describe work environment (i.e.: temperature, noise levels, chemical/dust exposure, etc.).

Does the claimant wear personal protective equipment (i.e.: safety glasses/footwear, respiratory protection, ear protection, etc.)? If yes, please describe.

Is there any circumstances or facts that would cause you to question the validity of the claim? ❑ Yes ❑ No If yes, please explain.

I certify that the information given above is true and complete.	Date (YYYY/MM/DD)
Name (please print)	Telephone no.
Signature of the authorized person	Job title

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Attending physician statement – physical conditions

In order for Humania Assurance to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Surname	Given name(s)	
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occured? (YYYY/MM/DD)

What was the date of the patient's first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient's first visit as regards to the present disability period ? (YYYY/MM/DD)

According to the anamnesis and your clinical exam, is your patient's condition the result of an accidental event ❑ Yes ❑ No Please elaborate :

If your patient has an orthopaedic and/or musculo-skeletal condition, has an X-ray, MRI, or any other tests been performed? ❑ Yes ❑ No If yes, please attach a copy of the results of the X-ray, MRI, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of the disability? ❑ Yes ❑ No
If yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should not** do)? Please be specific.

Please indicate the date the patient stopped working or performing his/her daily activities based on your recommendation. (YYYY/MM/DD)

If a potential return to work date or return to daily activities has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)
❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual – Please provide the return to work protocol

Has the patient ever had the same or similar condition? ❑ Yes ❑ No If yes, please provide dates and complete description.

Is the patient's condition due to injury or sickness arising out of his/her employment? ❑ Yes ❑ No If yes, please elaborate.

Attending physician statement – physical conditions (continued)

Section B – Treatment - (suite)

Is your patient ❑ Right-handed ❑ Left-handed

Is your patient competent to manage his/her own financial affairs? ❑ Yes ❑ No

If the patient was/is pregnant, please indicate the date or expected date of delivery. (YYYY/MM/DD)

Section C – Treatment

Frequency of patient visits ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Other _____

Please detail the patient's past and present treatment *(e.g.: date and type of surgery)* as well as response to treatment.

Has the patient been hospitalized? ❑ Yes ❑ No If yes, please provide the name of the hospital(s) and the dates of admission.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Have you treated or has the patient consulted you during the last **5 years prior** to the last illness? ❑ Yes ❑ No

Did the patient, to your knowledge, receive treatment during the **last 5 years** from any other health professional, or in any hospital or institution? ❑ Yes ❑ No

If «Yes», to either question, please furnish the following:

Name Address Nature of illness or injury Dates

_____ (YYYY/MM/DD)

_____ (YYYY/MM/DD)

_____ (YYYY/MM/DD)

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License no.
Address (no., street)		
Telephone no.	Fax no.	

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Attending physician statement – psychological conditions

In order for Humania Assurance to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Surname	Given name(s)	
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I

II

III

IV

V

Is there a secondary diagnosis or additional complication which might affect the duration of the disability? ❑ Yes ❑ No
If yes, please elaborate.

When did symptoms first appear? (YYYY/MM/DD)

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What was the date of the patient's first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient's first visit during the present disability period? (YYYY/MM/DD)

Please describe the patient's initial reason for seeking treatment. Was there a precipitating event?

Is your patient's condition caused directly or indirectly by his/her employment? ❑ Yes ❑ No If yes, please elaborate.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should not** do)? Please be specific.

Is your patient competent to manage his/her own financial affairs? ❑ Yes ❑ No

Please indicate the date the patient stopped working or performing his/her daily activities based on your recommendation. (YYYY/MM/DD)

If a potential return to work date or return to daily activities has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)
❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual – Please provide the return to work protocol

Attending physician statement – psychological conditions (continued)

Section C – Treatment

Frequency of patient visits ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Other _____

Please detail the patient's past and present treatment (including psychotherapy), response to treatment, and compliance.

Has the patient been hospitalized? ❑ Yes ❑ No If yes, please provide the name of the hospital(s) and the dates of admission.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

Have you treated or has the patient consulted you during the **last 5 years prior** to the last illness? ❑ Yes ❑ No

Did the patient, to your knowledge, receive treatment during the **last 5 years** from any other health professional or in any hospital or institution? ❑ Yes ❑ No

If «Yes», to either question, please furnish the following:

Name	Address	Nature of illness or injury	Dates
			(YYYY/MM/DD)
			(YYYY/MM/DD)

Section D – Functional capacities evaluation

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

None: no impairment in this area.
Mild: suspected impairment of slight importance which does not affect functional ability.
Moderate: impairment affects but does not predude ability to function.
Moderately severe: impairment significantly affects ability to function.
Severe: extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	❑	❑	❑	❑	❑
2. Ability to attend to personal care (bathing, cooking, etc.)	❑	❑	❑	❑	❑
3. Ability to carry out household chores	❑	❑	❑	❑	❑
4. Ability to relate to co-workers and supervisors	❑	❑	❑	❑	❑
5. Perform work where contact with others will be minimal	❑	❑	❑	❑	❑
6. Understand, carry out, and remember instructions	❑	❑	❑	❑	❑
7. Perform tasks involving minimal intellectual effort or repetitive tasks	❑	❑	❑	❑	❑
8. Perform varied tasks	❑	❑	❑	❑	❑
9. Ability to follow a regular work schedule	❑	❑	❑	❑	❑
10. Make independent judgements	❑	❑	❑	❑	❑
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	❑	❑	❑	❑	❑
12. Supervise or manage others	❑	❑	❑	❑	❑

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License no.
Address (no., street)		
Telephone no.	Fax no.	

To avoid any delay in the assessment of your claim, please complete and sign all the authorizations below, even if you completed the one found on page 3 of this document.

HUMANIA ASSURANCE

Authorization

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance will use the information provided for this claim and any prior claims under the same plan for the management of my claim and for production or statistical reports.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

Name (please print) _____ Signature _____

Policy no. _____ Date (YYYY/MM/DD) _____

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Authorization

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This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

Name (please print) _____ Signature _____

Policy no. _____ Date (YYYY/MM/DD) _____

Humania Assurance Inc., 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8 4300-013 - Rév. 04/2013

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Authorization

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This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

Name (please print) _____ Signature _____

Policy no. _____ Date (YYYY/MM/DD) _____

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Notes and Comments

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HUMANIA ASSURANCE INC.

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