Assumption Life
Group Insurance

DISABILITY CLAIM

REQUEST FOR EXTENSION

Assumption Life
Group Insurance

Disability Claim (request for extension) Instructions

If the employee is not currently receiving short-term or long-term benefits, please use the forms under "Disability Application – Initial Request".

If the employee is currently receiving short-term disability benefits and subsequently wishes to apply for long-term disability benefits, please use the "Disability Application – request for extension" form.

Employee

1. Please complete the "Employee's Statement" and ensure that you answer each question to avoid file review delays. Do not forget to sign the "Employee's Authorization & Acknowledgement" in section 3.

2. Please ensure that your attending physician completes the medical declarations that apply to your condition **(physical and/or psychological)**. You must also complete the "Employee Identification" section AND sign the authorization at the top of the "Attending Physician's Statement".

3. Please enclose a photocopy of the benefit statement from any government plan under which you are receiving benefits (Régie des rentes du Québec, Canada Pension Plan, workers' compensation, auto insurance, victim of criminal act compensation, etc.)

4. Attach a copy of all correspondence received from any government plan mentioned in number 3 above (such as a letter of acceptance, proof of payment, etc.) and, if possible, a copy of the file.

Please note:

a) It is your responsibility to pay any fees that may be incurred to have this form completed by your attending physician.

b) Please return the entire document to the following address and include all pages. **Please do not use staples.**

ASSUMPTION LIFE, c/o Group Insurance
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
Telephone: 1-855-244-7011 Fax: 1-855-401-9068

c) Alternatively, you can **scan** and **e-mail** the forms to: lifedisability@assumption.ca

Attending Physician

1. Please complete the medical declarations that apply to your patient's condition **(physical and/or psychological)** ensuring that you answer each question to avoid file review delays.

2. Please attach to the form any other documentation pertinent to the evaluation of this claim (test results of various examinations carried out and specialist consultation reports).

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P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 E-mail: lifedisability@assumption.ca

Assumption Life
Group Insurance

Reset

Disability Claim (request for extension) Employee's Statement

Type of claim : ☐ **Short-Term Disability** ☐ **Long-Term Disability** ☐ **Waiver of Premium**

To speed processing, please answer all questions and obtain all required signatures.

First Name _____ Last Name _____ Policy _____ Division _____ Certificate _____

Email _____ Language: ☐ French ☐ English ___ / ___ / _____ Date of birth (DD/MM/YYYY) Gender: ☐ F ☐ M

Address _____ City _____ Province _____ Postal Code _____

Telephone – Home _____ Telephone - Cell _____ Fax _____

Section 1 Current Situation

1. Since the date of your initial request:

   Are you confined to your home? ☐ Yes ☐ No
   Are you confined to your bed? ☐ Yes ☐ No
   Have you been hospitalized? ☐ Yes ☐ No From (DD/MM/YYYY) ___ / ___ / _____ to ___ / ___ / _____

2. List all physicians consulted since last report.

Illness	Consultation or Treatment Date (DD/MM/YYYY)	Treatment Prescribed, Medication, Other	Name of Physician	Address of Physician
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			

3. Please describe all your symptoms, including their severity and frequency, as well as any changes in your condition since your last report. _____

4. Describe your current activities of daily living since going on sick leave. _____

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Assumption Life
Group Insurance

Name of employee: _____

Section 1 Current Situation (continued)

5. Describe any limitations (cannot do) and/or restrictions (should not do) which prevent you from working. _____
_____
_____
_____
_____
_____
_____
_____

6. When do you expect to return to work? (DD/MM/YYYY) ___ / ___ / _____ ☐ Part-time ☐ Full-time ☐ Gradual return

Section 2 Income from Other Sources

1. Are you currently performing any work, even part-time, for which you receive any form of compensation? ☐ Yes ☐ No

2. Please indicate your entitlement to Disability Benefits, Income Replacement or Waiver of Premiums from these sources as a result of your health problem.

Source	Applied	Intend to Apply	Date of Claim Submission (DD/MM/YYYY)	Benefit Commencement Date (DD/MM/YYYY)	Amount and Frequency of Payment
Canada/Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Retirement Income/ Social Security	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
WSIB/WCB/CSST	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Employment Insurance Canada	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Car Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
War Veteran's Disability Pension	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Group Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Individual Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Other (specify): _____	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	

PROVIDE A COPY OF CORRESPONDENCE CONFIRMING BENEFIT PAYMENT.

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Assumption Life
Group Insurance

Name of employee: _____

Section 3 Employee s Authorization & Acknowledgement

I certify that the information given on this form is true, correct and complete.

For purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize Assumption Mutual Life Insurance Company, its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), workers compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of myself, to give to Assumption Life full particulars of such information, including, without limiting the generality of the foregoing, any information regarding my lifestyle, health, prior medical history and benefits.

I transfer and assign to Assumption Life, and agree to pay and refund to Assumption Life those disability and income replacement benefits which I receive or that are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Workers' Compensation, and other insurance policies.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or any professional organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating such fraud or abuse.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

_____

First and last name of employee (in block letters)

_____ _____

Employee's Signature Date (DD/MM/YYYY)

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Assumption Life
Group Insurance

Disability Claim (request for extension) Attending Physician s Statement Physical Illness

Section 1 To Be Completed by the Employee

First Name	Last Name	Policy	Division	Certificate

___ / ___ / _____
Date of birth (DD/MM/YYYY)

Telephone – Home

Telephone - Cell

I hereby authorize any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physician's notes) or knowledge concerning myself with Assumption Mutual Life , its employees, reinsurers or agency acting on behalf of Assumption Mutual Life which is necessary for the purpose of assessing my disability claim. A photocopy of this authorization shall be as valid as the original. This authorization is valid only for this disability claim.

Employee's Signature

Date (DD/MM/YYYY)

Section 2 To Be Completed by the Attending Physician

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE EVALUATION OF THIS CLAIM.

1. Diagnosis

A) Primary: _____

B) Secondary: _____

C) Objective tests performed as part of the physical examination/investigation:

☐ Scan ☐ MRI ☐ ECG ☐ Other tests/investigations performed: _____

Please attach copies of the recent test results.

D) Is the patient: ☐ Right-handed ☐ Left-handed

E) Please list the symptoms that you have personally noted. _____

_____

_____

_____

_____

_____

2. Treatments and Visits

A) Medications:

Date started (DD/MM/YYYY)	Name	Dosage	Frequency
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			

B) Additional treatments (please specify the type and frequency) _____

_____

_____

_____

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Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

2. Treatment and Visits (continued)

C) Surgery (date and nature of the procedure) _____

D) Hospitalization: From (DD/MM/YYYY) ___ / ___ / _____ to ___ / ___ / _____
Name of hospital _____ Location _____

E) Name(s) of specialist(s) consulted: _____
_____

3. Medical Follow-Up and Prognosis

A) Date of last visit: (DD/MM/YYYY) ___ / ___ / _____
Date of next visit: (DD/MM/YYYY) ___ / ___ / _____

B) Tests and examinations scheduled (please specify): _____
_____
_____

C) Frequency of visits: _____

D) Referral to specialist(s)? ☐ Yes ☐ No

Name of physician: _____ Date of referral: (DD/MM/YYYY) ___ / ___ / _____
Name of physician: _____ Date of referral: (DD/MM/YYYY) ___ / ___ / _____
Name of physician: _____ Date of referral: (DD/MM/YYYY) ___ / ___ / _____
Name of physician: _____ Date of referral: (DD/MM/YYYY) ___ / ___ / _____

E) Describe the **functional limitations** that prevent your patient from attending to duties or from going about usual activities. _____
_____
_____
_____
_____
_____
_____
_____

F) Progress: ☐ Improving ☐ Stable ☐ No change ☐ Regressing

G) If you anticipate that the absence from work will extend beyond the usual period of recovery for a diagnosis of this type, please indicate the factors on which your prognosis is based. _____
_____
_____
_____
_____
_____

H) Patient's compliance with treatment: ☐ Excellent ☐ Average ☐ Poor

I) Would it be helpful for your patient to receive assistance in returning to work? ☐ Yes ☐ No

J) ☐ Expected date of return to work: (DD/MM/YYYY) ___ / ___ / _____
☐ Date returned to work: (DD/MM/YYYY) ___ / ___ / _____
☐ Indeterminate

K) How soon will the patient be able to perform his/her regular work? (DD/MM/YYYY) ___ / ___ / _____
How soon will the patient be able to perform any other work? (DD/MM/YYYY) ___ / ___ / _____
☐ Part-time ☐ Full-time ☐ Gradually Please specify: _____

L) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

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Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

4.Limitations and Restrictions

A) Heart condition (if applicable)

Functional capacity according to the American Heart Association

☐ Class I (no limitation) ☐ Class II (slight limitation) ☐ Class III (marked limitation) ☐ Class IV (severe limitation)

B) Please indicate how much time the patient can spend performing the following actions during a regular 8-hour workday.

Sitting:	☐ < 1 hour	☐ 1 hour	☐ 2 hours	☐ 3 hours	☐ 4 hours	☐ 5 hours	☐ 6 hours	☐ 7 hours	☐ 8 hours
Standing:	☐ < 1 hour	☐ 1 hour	☐ 2 hours	☐ 3 hours	☐ 4 hours	☐ 5 hours	☐ 6 hours	☐ 7 hours	☐ 8 hours
Walking:	☐ < 1 hour	☐ 1 hour	☐ 2 hours	☐ 3 hours	☐ 4 hours	☐ 5 hours	☐ 6 hours	☐ 7 hours	☐ 8 hours

C) During a regular 8-hour workday, the patient is able to lift or carry (check 1 box):

☐ Objects weighing more than 100 lbs. and frequently lift and carry objects weighing 50 lbs.
☐ Objects weighing up to 100 lbs. and frequently lift and carry objects weighing up to 50 lbs.
☐ Objects weighing up to 50 lbs. and frequently lift and carry objects weighing up to 25 lbs.
☐ Objects weighing up to 20 lbs. and frequently lift and carry objects weighting up to 10 lbs.
☐ Objects weighing up to 10 lbs. and occasionally carry small objects

D) Please indicate the actions that the patient is able to perform during a regular 8-hour workday as well as the percentage.

Limb Functions		Occasionally (0-33%)	Frequently (34-66%)	Continuously (67-100%)	Never
Simple grasping	LUL / RUL				
Fine manipulation	LUL / RUL				
Keyboarding (using fingers)	LUL / RUL				
Rotation – extension of the shoulder	LUL / RUL				
Rotation – extension of the elbow	LUL / RUL				
Use of foot controls	LLL / RLL				

LUL: Left Upper Limb **RUL: Right Upper Limb** **LLL: Left Lower Limb** **RLL: Right Lower Limb**

E) Does the patient have any other **limitations** (cannot do) or **restrictions** (should not do) not mentioned above?

Temporary duration: _____
_____
_____
_____

Permanent: _____
_____
_____
_____

F) If your patient is pregnant, what is the expected date of delivery? (DD/MM/YYYY) ___ / ___ / _____

Please indicate the signs and symptoms, as well as the medical reasons that are preventing your patient from doing her work. _____
_____
_____
_____
_____
_____

Please attach the most recent obstetrical report.

G) General comments: _____
_____
_____
_____
_____

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Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

5. Identification of the Attending Physician

First Name _____ Last Name _____

Full Address _____

Telephone _____ Fax _____

☐ General Practitioner ☐ Specialist (specify) _____ ☐ Other (specify) _____

_____ _____

Signature of Attending Physician Date (DD/MM/YYYY)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

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Assumption Life
Group Insurance

Disability Claim (request for extension) Attending Physician s Statement Psychological Illness

Section 1 To Be Completed by the Employee

First Name	Last Name	Policy	Division	Certificate

___ / ___ / _____
Date of birth (DD/MM/YYYY)

Telephone – Home

Telephone - Cell

I hereby authorize any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, worker's compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physician's notes) or knowledge concerning myself with Assumption Mutual Life , its employees, reinsurers or agency acting on behalf of Assumption Mutual Life which is necessary for the purpose of assessing my disability claim. A photocopy of this Authorization shall be as valid as the original. This authorization is valid only for this disability claim.

Employee's Signature

Date (DD/MM/YYYY)

Section 2 To Be Completed by the Attending Physician

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE EVALUATION OF THIS CLAIM.

1. Diagnosis

A) (Axis I) Psychiatric Disorder: _____

B) Please describe the signs and symptoms, indicating the frequency and the degree of severity of each one:
(M=Mild MD=Moderate S=Severe)

Signs	M	MD	S	Symptoms	M	MD	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

C) (Axis II) Are there any associated personality disorders? ☐ Yes ☐ No Specify: _____

D) (Axis II) Are there any associated drug addiction, alcoholism or gambling problems? ☐ Yes ☐ No
If yes, specify: _____

E) (Axis III) General medical condition
Diagnosis: _____
_____
Medication prescribed: _____
_____
_____

F) (Axis IV) Associated psychosocial problems (in the past 12 months)

☐ Marital/family life ☐ Loss of employment ☐ Alcohol or drug abuse and/or gambling problems
☐ Professional problems ☐ Personal or interpersonal problems ☐ Other (specify): _____

G) (Axis V) Global Assessment of Functioning
- Highest level in the past year - GAF score (0-100):_____
- Highest level currently - GAF score (0-100): _____

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Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

2. Treatment and Visits

A) Medications:

Date Started (DD/MM/YYYY)	Name	Dosage	Frequency
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			
___ / ___ / _____			

B) Treatment strategies with medication:

- Increased on (DD/MM/YYYY) ___ / ___ / _____ Name and dosage: _____
- Maximized on (DD/MM/YYYY) ___ / ___ / _____ Name and dosage: _____
- Combined on (DD/MM/YYYY) ___ / ___ / _____ Name and dosage: _____

C) Please indicate whether your patient is consulting:

			Since when? (DD/MM/YYYY)
A psychiatrist?	☐ Yes	☐ No	___ / ___ / _____
A psychologist?	☐ Yes	☐ No	___ / ___ / _____
A social worker?	☐ Yes	☐ No	___ / ___ / _____
Another health professional?	☐ Yes	☐ No	___ / ___ / _____

D) Is your patient receiving follow-up:

			Please specify:
At a treatment center?	☐ Yes	☐ No	_____
At a health care center?	☐ Yes	☐ No	_____
At a day hospital?	☐ Yes	☐ No	_____
In group therapy?	☐ Yes	☐ No	_____
In individual therapy?	☐ Yes	☐ No	_____

3. Follow-Up and Prognosis

A) Date of last visit: (DD/MM/YYYY) ___ / ___ / _____

B) Frequency of visits: _____

C) Will the patient be or has the patient been referred to a psychiatrist? ☐ Yes ☐ No
Name of physician: _____ Date of referral: (DD/MM/YYYY) ___ / ___ / _____

D) Patient's compliance with treatment ☐ Excellent ☐ Average ☐ Poor

E) If you anticipate that the absence from work will extend beyond the usual period for a diagnosis of this type, please indicate the parameters on which your prognosis is based. _____
_____
_____
_____
_____

F) Would it be helpful for your patient to receive assistance in returning to work? ☐ Yes ☐ No

G) In your opinion, has the patient's condition reached an optimal level of improvement? ☐ Yes ☐ No

H) ☐ Expected date of return to work (DD/MM/YYYY) ___ / ___ / _____
☐ Date returned to work (DD/MM/YYYY) ___ / ___ / _____
☐ Indeterminate

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Assumption Life
Group Insurance

Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

3. Follow-Up and Prognosis (continued)

I) Is your patient fit to perform his/her regular work? ☐ Yes ☐ No
Is your patient fit to perform any other work? ☐ Yes ☐ No

J) When will the patient be able to return to work? (DD/MM/YYYY) ___ / ___ / _____

☐ Part-time ☐ Full-time ☐ Gradual return Please explain why: _____

_____

K) Recommended return to work plan:
Program start date: (DD/MM/YYYY) ___ / ___ / _____
Week 1 _____ days/week Date (DD/MM/YYYY) ___ / ___ / _____ Week 3 _____ days/week Date (DD/MM/YYYY) ___ / ___ / _____
Week 2 _____ days/week Date (DD/MM/YYYY) ___ / ___ / _____ Week 4 _____ days/week Date (DD/MM/YYYY) ___ / ___ / _____

4. Rating Mental/Functional Impairment

Legend:	None	0	No limitation
	Mild	1	Slight limitation but no impairment of functional capacity
	Moderate	2	Moderate limitation but no impairment of functional capacity
	Marked	3	Significant impairment of functional capacity
	Severe	4	Total impairment of functional capacity

Please circle the number that corresponds to your assessment, as indicated in the legend above.

1. Ability to maintain interpersonal relationships and relationships of trust	0	1	2	3	4
2. Ability to go about personal and domestic activities of daily living	0	1	2	3	4
3. Ability to maintain an interest level	0	1	2	3	4
4. Ability to understand and keep in mind instructions and carry them out	0	1	2	3	4
5. Ability to respond adequately to supervision	0	1	2	3	4
6. Ability to perform tasks requiring regular contact with others	0	1	2	3	4
7. Ability to perform tasks requiring little contact with others	0	1	2	3	4
8. Ability to perform tasks involving minimal intellectual exertion	0	1	2	3	4
9. Ability to perform complex tasks requiring a high level of reasoning, mathematical ability and speech	0	1	2	3	4
10. Ability to perform repetitive tasks at an adequate pace	0	1	2	3	4
11. Ability to perform a variety of tasks	0	1	2	3	4
12. Ability to perform tasks with consistency and rhythm	0	1	2	3	4
13. Ability to make decisions	0	1	2	3	4
14. Perseverance	0	1	2	3	4
15. Ability to supervise or manage staff	0	1	2	3	4
16. Ability to handle stress in situations requiring attention to detail and quick turnarounds.	0	1	2	3	4

A) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

B) General Comments _____

_____

_____

5. Identification of the Attending Physician

First Name _____ Last Name _____
Full Address _____
Telephone _____ Fax _____

☐ General Practitioner ☐ Specialist (specify) _____ ☐ Other (specify) _____

_____ _____
Signature of Attending Physician Date (DD/MM/YYYY)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

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