Assumption Life
Group Insurance

DISABILITY CLAIM

(INITIAL REQUEST)

Assumption Life
Group Insurance

Disability Claim (Initial Request) Instructions

Policyholder (employer or plan administrator)

1. Please complete the "Policyholder's Statement" and ensure that you answer all questions to avoid file review delays.

2. For long-term disability benefits or waiver of premium benefits (without short-term disability coverage requests), Assumption Life must receive the duly completed form signed by all parties **6 to 8 weeks before the waiting period expires**.

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 7.

2. Please ensure that your attending physician completes the medical declarations that applies 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 applies to your patient's condition **(physical and/or psychological)** ensuring that you answer all questions to avoid file review delays.

2. Please provide 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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Assumption Life
Group Insurance

Disability Claim (Initial Request) Policyholder's Statement

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

To speed processing, please answer all questions. Please Print.

Name of Policyholder: ______________________ Authorized Person's Name: ______________________

Address: ______________________ City: __________ Province: __________ Postal Code: __________

Telephone: __________ Email: ______________________ Fax: __________

Section 1 Employee Information

Employee's First Name: __________ Employee's Last Name: __________ Policy: ______ Division: ______ Certificate: ______

1. Occupation (Please attach a copy of the job description and complete the information below)

Current position: ______________________ Start Date: (DD/MM/YYYY) ___ / ___ / _____

Type of position: ☐ Regular fulltime position ☐ Regular part-time position ☐ Term employee ☐ Seasonal employee

Is the employee: ☐ Hourly ☐ Salaried ☐ Commissioned (Please provide T4 for the last 3 years)

2. Physical Work Environment

A) What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties: ______________________ _____ % Duties: ______________________ _____ %
Duties: ______________________ _____ % Duties: ______________________ _____ %

For questions B, D and E, FREQUENCY is defined as follows:
Occasionally : 0%-15% of the time Frequently : 16%-50% of the time Always : 51%–100% of the time

B) Work environment – Does the employee's job require work in any of the following conditions?

Frequency	O	F	A	Frequency	O	F	A	Frequency	O	F	A
☐ Outside	☐	☐	☐	☐ Above or below ground level	☐	☐	☐	☐ In extremes of cold or heat	☐	☐	☐
☐ Toxic fumes	☐	☐	☐	☐ In a damp or humid environment	☐	☐	☐	☐ Handling of chemicals	☐	☐	☐

C) Does the job involve other hazards? ☐ Yes ☐ No
If yes, please list: ______________________

D) Check the items below that relate to the employee's job:

Frequency	O	F	A	Frequency	O	F	A	Frequency	O	F	A
☐ Standing	☐	☐	☐	☐ Bending over	☐	☐	☐	☐ Crouching	☐	☐	☐
☐ Walking	☐	☐	☐	☐ Keeping one's balance	☐	☐	☐	☐ Climbing	☐	☐	☐
☐ Sitting	☐	☐	☐	☐ Extending/reaching above head	☐	☐	☐	☐ Stairs (number _______)	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐ Crawling	☐	☐	☐	☐ Ladders (height _______)	☐	☐	☐

E) Describe activity and specify frequency and weight:

Activity	Frequency: O	F	A	Weight:
☐ Pushing: ______________________	☐	☐	☐	_________ ☐lb ☐kg
☐ Pulling: ______________________	☐	☐	☐	_________ ☐lb ☐kg
☐ Lifting/carrying: ______________________	☐	☐	☐	_________ ☐lb ☐kg

F) Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment: ______________________ Times per day: __________
Type of equipment: ______________________ Times per day: __________

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Assumption Life
Group Insurance

________	________	________	________	________
Employee's First Name	Employee's Last Name	Policy	Division	Certificate

Section 1 Employee Information (continued)

G) Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? ☐ Yes ☐ No If yes, please specify: ____________________

____

____

____

H) Does the employee's job require dexterity? ☐ Yes ☐ No If yes, please specify: ____________________

____

____

____

I) Are there any other potential work-related factors which may influence this employee's return to work? ☐ Yes ☐ No
If yes, please specify: ____________________

____

____

____

3. Cognitive / Non-Physical Work Environment

A) Does the employee have to answer complaints? ☐ Yes ☐ No

B) Is the employee primarily evaluated on production? ☐ Yes ☐ No

C) Does the employee work closely with coworkers? ☐ Yes ☐ No

D) Is the employee responsible for the performance objectives / decision making within his/her particular department? ☐ Yes ☐ No

E) Number of people the employee supervises: ________________

F) What percentage (%) of the employee's time is spent in the following activities?
Talking: ____________ (%) Writing: ____________ (%) Supervising other people: ____________ (%)

G) Please list any other relevant aspects of the job that may be considered stressful: ____________________

____

____

____

____

4. Job Tasks and Performance

A) When did the employee's health problem first appear to affect his/her work? (DD/MM/YYYY) ___ / ___ / _____

B) In what ways did on-the-job performance change as a result of this health problem? ____________________

____

____

____

C) Were any changes made in the employee's job duties as a result of this health problem? ☐ Yes ☐ No
If yes, please specify: ____________________

____

____

____

D) If the employee could return to part-time or less demanding work, would such work be available? ☐ Yes ☐ No
If no, please explain: ____________________

____

____

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Employee's First Name	Employee's Last Name	Policy	Division	Certificate

Section 1 – Employee Information (continued)

5. Coverage and Employment

A) Was the coverage in effect on the first day of the current period of absence from work? ☐ Yes ☐ No

If yes, what is the effective date of the employee's disability insurance coverage? (DD/MM/YYYY) ___ / ___ / _____
If no, please explain: ____

B) Effective date of coverage with previous insurer, if disability began less than 12 months from the effective date of current coverage :
Date: (DD/MM/YYYY) ___ / ___ / _____

C) Date hired: (DD/MM/YYYY) ___ / ___ / _____ Start date of current position: (DD/MM/YYYY) ___ / ___ / _____

Last day at work: (DD/MM/YYYY) ___ / ___ / _____ Number of hours worked: _____________________

D) Date of return to work (if applicable): (DD/MM/YYYY) ___ / ___ / _____ ☐ Full time ☐ Part time ☐ Regular Position

E) Primary reason for current absence from the workplace:

☐ Occupational illness ☐ Motor vehicle accident ☐ Pregnancy related condition
☐ Illness ☐ Accident outside of work ☐ Accident at work

F) On the date the current period of absence from work began, was the employee:

☐ On **paid** leave ☐ Laid off ☐ On disciplinary suspension **without** pay ☐ Other: _____________________
☐ On **unpaid** leave ☐ On vacation ☐ On disciplinary suspension **with** pay

Section 2 – Employee's Work Schedule and Earnings Information

1. Indicate the hours of work in a normal week: _______________ For an irregular schedule, indicate the daily schedule.
Monday ______ Tuesday ______ Wednesday ______ Thursday ______ Friday ______ Saturday ______ Sunday ______

2. Gross salary prior to date of disability: $____________ ☐ Annual ☐ Monthly ☐ Biweekly ☐ Weekly ☐ Bimonthly
For ____________________ (number of hours) Salary effective date: (DD/MM/YYYY) ___ / ___ / _____

3. Tax credits: Federal (TD1): ________________ Provincial (TPD1): ________________

4. Has or will the employee receive other amounts apart from the disability insurance benefits during the current period of absence from work? ☐ Yes ☐ No For the period of ____________________ to ____________________
Specify: ☐ Vacation ☐ Maternity leave ☐ Employment insurance (HRSDC) ☐ Sick leave ☐ Statutory holidays

5. Has the employee applied or will he/she be applying to any of the organizations below? ☐ Yes ☐ No

If so, please specify: ☐ Commission de la santé et de la sécurité du travail (CSST) or other workers' compensation organization
☐ Société de l'assurance automobile du Québec (SAAQ) or other similar organization
☐ Human Resources and Social Development Canada (HRSDC)
Canada Pension Plan (CPP) - ☐ Disability pension / ☐ Retirement pension
Régie des rentes du Québec (RRQ) - ☐ Disability pension / ☐ Retirement pension

6. If the employee is already receiving benefits from one of the sources above, please specify the amount/frequency: $________/_______
<u>**Attach a copy of the letter of acceptance.**</u>

7. If the employee is pregnant, has an application for a preventative withdrawal been submitted to the CSST (Québec only), or will it be?
☐ Yes ☐ No

8. Has the employee returned to work? ☐ Yes ☐ No If yes, on what date? (DD/MM/YYYY) ___ / ___ / _____

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Assumption Life
Group Insurance

Employee's First Name	Employee's Last Name	Policy	Division	Certificate

Section 2 Employee s Work Schedule and Earnings Information

9. Is this person still in your employ? ☐ Yes ☐ No
   If no, specify termination date. (DD/MM/YYYY) ___ / ___ / _____
   Reason: ____

10. Was this person given a record of employment? ☐ Yes ☐ No

11. Please provide any additional information that you believe should be considered in assessing this employee's claim.

____

First and last name of the authorized person (in block letters) ______________________

Position ______________________

Signature ______________________

Date (DD/MM/YYYY) ______________________

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Assumption Life
Group Insurance

Disability Claim (Initial Request) Employee's Statement

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

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

First Name ____ Last Name ____ Policy ____ Division ____ Certificate ____

Social Insurance Number ____ Language: ☐ French ☐ English ___ / ___ / _____ Date of birth (DD/MM/YYYY) Gender: ☐ F ☐ M

Address ____ City ____ Province ____ Postal Code ____

Fax ____ E-mail ____

Telephone - Home ____ Telephone – Work ____ Telephone - Cell ____

Section 1 General Information

Training: ____
Level of education: ____
Work experience: ____

Spoken language: ☐ French ☐ English
Written language: ☐ French ☐ English

If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy Number	Certificate Number	Date Benefits Commenced (DD/MM/YYYY)	Benefit Period (DD/MM/YYYY)	Benefit Amount	Weekly or Monthly
			___/ ___/ _____	___/ ___/ _____ to ___/ ___/ _____	$	☐ W ☐ M
			___/ ___/ _____	___/ ___/ _____ to ___/ ___/ _____	$	☐ W ☐ M
			___/ ___/ _____	___/ ___/ _____ to ___/ ___/ _____	$	☐ W ☐ M

Section 2 Reason for the Claim

1. If the sick leave was the result of an accident, indicate:

A) Place of the accident: ☐ Home ☐ Work ☐ Elsewhere (specify) ____

B) Date of the accident: (DD/MM/YYYY) ___ / ___ / _____

C) Circumstances: ____

D) If a car accident, specify whether you were: ☐ the driver ☐ a passenger <u>If not a Quebec resident, please submit the police report.</u>

2. Is your current absence from the workplace due to work-related issues? ☐ Yes ☐ No Please elaborate: ____

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Assumption Life
Group Insurance

Name of employee: ____

Section 3 Occupation

Date hired: (DD/MM/YYYY) ___ / ___ / _____ When did you become unable to work? (DD/MM/YYYY) ___ / ___ / _____

1. Explain how your condition is preventing you from working. ___________________________________

2. Describe the duties of your job that you can no longer perform. ___________________________________

3. When you stopped working, were you working elsewhere (second job)? ☐ Yes ☐ No If yes, specify: ___________________

Section 4 Current Situation

1. A) Are you confined to your home? ☐ Yes ☐ No
   B) Are you confined to your bed? ☐ Yes ☐ No
   C) Are you hospitalized? ☐ Yes ☐ No

2. Please describe all your symptoms, including severity and frequency. ___________________________________

3. Describe your current activities of daily living since going on sick leave. ___________________________________

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Assumption Life
Group Insurance

Name of employee: ____

Section 5 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 payments from these sources as a result of your current 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.

Section 6 Physicians and History

1. Name of you attending physician: ____ Date of initial visit: (DD/MM/YYYY) ___ / ___ / _____
   Address: ____
   Telephone: ____ Fax : ____

2. Have you been hospitalized for this medical condition? ☐ Yes ☐ No Date: (DD/MM/YYYY) ___ / ___ / _____
   Name of Hospital: ____ Location: _________________________

3. When did your symptoms begin? ____
   ____
   ____

4. When did you first consult a physician for this medical condition? ____

5. Have you ever had a similar illness or injury before? ☐ Yes ☐ No Date: (DD/MM/YYYY) ___ / ___ / _____

6. Would you be able to return to work gradually? ☐ Yes ☐ No

7. Has your attending physician prescribed medication? ☐ Yes ☐ No If yes, are you taking it regularly? ☐ Yes ☐ No

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Group Insurance

Name of employee: ____

Section 6 Physicians and History (continued)

8. List all the physicians who have treated you in the last two years.

Illness	Consultation or treatment date	Treatment prescribed, medication, other	Name of Physician	Address of physician
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			

Section 7 Employee s Authorization & Acknowledgement

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

For purpose of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize Assumption Life, 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 disabilities and income replacement benefits which I receive or 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.

____
Name (in block letters)

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

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Assumption Life
Group Insurance

Disability Claim (Initial Request) Attending Physician's Statement Physical Illness

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

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 RELEVANT TO THE ASSESSMENT OF THIS CLAIM.

1. Diagnosis

A) Primary Diagnosis: ______

B) Secondary Diagnosis: ______

C) Complications: ______

D) For illnesses or associated symptoms diagnosed, has the patient previously:

☐ Received medical treatments ☐ Consulted another physician ☐ Been hospitalized ☐ Taken medication ☐ Undergone examinations

Specify the periods: ______

E) Is the disability related to the specific risks of this patient's job? ☐ Yes ☐ No If yes, please explain: ______

F) Is the disability related to: ☐ A car accident ☐ An accident ☐ A work accident ☐ An illness ☐ An occupational illness

Date of the event: (DD/MM/YYYY) ___ / ___ / _____

G) Pregnancy? ☐ Yes ☐ No Expected date of delivery: (DD/MM/YYYY) ___ / ___ / _____
Preventative leave? ☐ Yes ☐ No Start date : (DD/MM/YYYY) ___ / ___ / _____

H) Describe the functional limitations that prevent the patient from carrying out professional duties or usual daily activities.

At the beginning of disability Date: (DD/MM/YYYY) ___ / ___ / _____	Currently

I) **Height?** ________ ft/in OR ________ m/cm **Weight?** ________ lbs OR ________ kg ☐ **Right-handed** ☐ **Left-handed**

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Assumption Life
Group Insurance

Name of employee: ____

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

2. Limitations and Restrictions

A) What are your patient's current limitations? (what he/she cannot do) ____

B) What restrictions are currently placed on your patient? (what he/she should not do) ____

C) Is the patient able to attend to his/her affairs, particularly the endorsement of cheques? ☐ Yes ☐ No

D) Cardiac status (if related to the disability):

Functional Capacity (American Heart Association) ☐ Class I (no limitation) ☐ Class III (marked limitation) ☐ Class II (slight limitation) ☐ Class IV (severe limitation)

Blood pressure (last visit) Systolic ________________ Diastolic ________________

E) Current Work Capabilities:

☐ Sedentary
- Lifting 10 lbs. maximum
- Occasional lifting and/or carrying
- Primarily sitting, with occasional walking/standing

☐ Light
- Lifting 20 lbs. maximum
- Frequent lifting and/carrying up to 10 lbs.
- May require walking/standing to a significant degree
- May involve sitting with pushing and pulling of arm and/or leg controls

☐ Medium
- Lifting 50 lbs. maximum
- Frequent lifting and/or carrying up to 20 lbs
- May involve sitting with pushing and pulling of arm and/or leg controls

☐ Heavy
- Lifting 100 lbs. maximum
- Frequent lifting and/or carrying up to 50 lbs.

Comments: ____

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Group Insurance

Name of employee: ____

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

3. Treatment

A) Medications:

Name: ____________________ Dosage: ____________________
Name: ____________________ Dosage: ____________________
Name: ____________________ Dosage: ____________________
Name: ____________________ Dosage: ____________________
Name: ____________________ Dosage: ____________________
Name: ____________________ Dosage: ____________________

B) Has the patient undergone or will he/she undergo:

Examination or tests ☐ Yes ☐ No Specify: ____________________
A short stay under observation ☐ Yes ☐ No Number of hours: ____________________
Surgery ☐ Yes ☐ No ☐ Day Procedure Date: (DD/MM/YYYY) ___ / ___ / _____ Type: ____________________
Other treatments (physio, etc.) ☐ Yes ☐ No Type: ____________________ Name of practitioner: ____________________
Date of commencement: (DD/MM/YYYY) ___ / ___ / _____

C) Hospitalization: from (DD/MM/YYYY) ___ / ___ / _____ to ___ / ___ / _____
Name of Hospital: ____________________ Location ____________________

4. Follow-Up and Prognosis

A) Date of first consultation for this health condition: (DD/MM/YYYY) ___ / ___ / _____
Date health condition first prevented him/her from returning to work: (DD/MM/YYYY) ___ / ___ / _____

B) Date of next consultation: (DD/MM/YYYY) ___ / ___ / _____
Dates of other consultations: (DD/MM/YYYY) ____________________
Follow-up frequency: ____________________

C) Referral to other physician(s): ☐ Yes ☐ No Name of physician(s): ____________________
____
Specialty: ____________________

D) Approximate duration of recovery: ☐ Number of weeks __________ ☐ Number of months __________ ☐ Undetermined

E) If applicable, date of return to work: (DD/MM/YYYY) ___ / ___ / _____
If he/she hasn't returned to work, when will he/she be fit to return to work? (DD/MM/YYYY) ___ / ___ / _____
☐ Part-time ☐ Full-time ☐ Gradual return Please explain why: ____________________
____

F) 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) ___ / ___ / _____

5. Identification of 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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Disability Claim (Initial Request) Attending Physician's Statement Psychological Illness

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

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 RELEVANT TO THE ASSESSMENT OF THIS CLAIM.

1. Diagnosis

A) Primary diagnosis (Axis I): ____________

B) Secondary (Axis II, III) - Personality disorders and other medical conditions: ____________

C) Among the current symptoms, please identify the ones that you observed during office visits. ____________

D) Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Accompanying psychotic elements

E) Does the interruption of work result from problems related to:

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

F) Current Global Assessment of Functionning (GAF) Score: ____________

G) Highest level of functioning (GAF score) in the last year (0-100): ____________

H) Current mental status examination (psychomotor activity, mood, affect, thinking, cognitive abilities): ____________

I) For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ Received medical treatment ☐ Been hospitalized ☐ Consulted another physician
☐ Undergone examinations ☐ Taken medication

Specify the dates of previous episodes (if applicable): (DD/MM/YYYY) ____________

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
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

Name of employee: ______________________________

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

2. Limitations and Restrictions

A) What are your patient's current limitations? (what he/she cannot do) ______________________________

B) What restrictions are currently placed on your patient? (what he/she should not do) ______________________________

C) Is the patient able to attend to his/her affairs, particularly the endorsement of cheques? ☐ Yes ☐ No

3. Treatment

A) Medications:

Name: ______________________________ Dosage: ______________________________
Name: ______________________________ Dosage: ______________________________
Name: ______________________________ Dosage: ______________________________
Name: ______________________________ Dosage: ______________________________
Name: ______________________________ Dosage: ______________________________
Name: ______________________________ Dosage: ______________________________

B) Medication Strategies (Please comment as extensively as possible):

Progressive increase: ______________________________

Potentialization: ______________________________

Medication combinations: ______________________________

Medication changes: ______________________________

C) Is the patient consulting: a psychiatrist? ☐ Yes ☐ No A social worker? ☐ Yes ☐ No
a psychologist? ☐ Yes ☐ No Another health care provider? (i.e. psychotherapist, counselor, etc.) ☐ Yes ☐ No

If yes, name of the caregiver(s): ______________________________

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

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Assumption Life
Group Insurance

Name of employee: ____

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

4. Follow-Up and Prognosis

A) Date of first consultation for this mental health condition: (DD/MM/YYYY) ___ / ___ / _____
Date mental health condition first prevented him/her from returning to work: (DD/MM/YYYY) ___ / ___ / _____

B) Date of next consultation: (DD/MM/YYYY) ___ / ___ / _____
Dates of other consultations: (DD/MM/YYYY) ____
Follow-up frequency: ____

C) Will the patient be referred to a psychiatrist? ☐ Yes ☐ No If yes, name of psychiatrist: ___________________________________

D) Approximate duration of disability: ☐ Number of weeks ___________ ☐ Number of months _____________ ☐ Undetermined

E) When will the patient be able to return to work? (DD/MM/YYYY) ___ / ___ / _____
☐ Part-time ☐ Full-time ☐ Gradual return Please explain why: ____
____
____

F) 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) ___ / ___ / _____

5. Identification of 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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