Assumption Life
Group Insurance

Reset

Dependent with a Total Disability Questionnaire

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

Dependent's First Name _____ Dependent's Last Name _____ Date of Birth ___/___/____ (DD /MM/ YYYY)

Section 1 To Be Completed by the Employee

1. Where does the dependent reside? ☐ With employee ☐ Special Care Facility ☐ Other (specify): _____
2. Does the dependent have an income? ☐ Yes ☐ No
   If yes, from what source? ☐ An employer ☐ CPP ☐ WHSCC ☐ Other (specify): _____
3. Does the dependent have a driver's license? ☐ Yes ☐ No
   If no, please explain why: _____
   If yes, does his disability prevent him from driving? ☐ Yes ☐ No
4. Did the dependent attend school? ☐ Yes ☐ No
   If yes, what grade did he/she complete? _____
5. In their daily activities, is the dependent: ☐ Independent ☐ Needs help
   Please provide details: _____
   _____
6. Is the dependent able to move and walk independently in their environment? ☐ Yes ☐ No
   Please provide details: _____
   _____

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

Section 2 To Be Completed by the Dependent's Physician

7. To the best of my knowledge, the above questions are answered correctly. ☐ Yes ☐ No
   If no, please explain: _____
8. His/her diagnosis is: _____
9. The date of his/her diagnosis (DD/MM/YYYY): ___ / ___ / _____
10. The start date of his/her disability (DD/MM/YYYY): ___ / ___ / _____
11. His/her treatment consists of: _____
12. His/her most significant current physical and/or mental
    limitations are: _____
    _____
    capabilities are: _____
    _____
13. Is the dependent considered disabled and totally incapable of pursuing any gainful occupation? ☐ Yes ☐ No
    If yes, please provide us with copies of consultation reports, test results and any other information that may assist us with our assessment.

_____ _____
Physician's Signature Date (DD/MM/YYYY)

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