SSQ Financial Group

Application for Disability Insurance Benefits

Statement of insured

Surname

Given name

Group no. | Certificate no.

Contract no.

Employer/Sponsor Name

Social Insurance no. (optional)

Mailing address

Postal code

Telephone (home)

Telephone (office) Extension

Date of birth (Y Y Y Y M M D D)

☐ F ☐ M Sex

Civil status: ☐ single ☐ single-parent ☐ married or common-law

Dependents: **Spouse:** ☐ no ☐ yes **Children:** ☐ no ☐ yes Number: _____ Age: _____

Name of Doctor

Since you stopped working, have you had any other employment? ☐ no ☐ yes → Date of beginning: (Y Y Y Y M M D D)

If yes, specify the nature of the employment

Is the disability the result of an accident? ☐ no ☐ yes → Describe the circumstances, including date and location.

Have you already undergone a medical assessment related to your disability? ☐ no ☐ yes

Do you receive or have you applied for benefits under any of the following programs or plans?

PROGRAM	NO	IF YES						IF DECLINED	
		Under study	Accepted	Reference No	Amount	Frequency of payments	Declined	Do you intend to appeal this decision? no	yes
PROGRAM Employment Insurance If yes, date payment of benefits began: (Y Y Y Y M M D D)	☐	☐	☐		$		☐	☐	☐
Worker's compensation	☐	☐	☐		$		☐	☐	☐
Provincial or Federal government agency	☐	☐	☐		$		☐	☐	☐
Automobile insurance law or any other compensation program	☐	☐	☐		$		☐	☐	☐
PLAN Retirement or pension plan	☐	☐	☐		$		☐	☐	☐
Salary continuance plan	☐	☐	☐		$		☐	☐	☐
Health or welfare plan	☐	☐	☐		$		☐	☐	☐
Any other group insurance plan: _____	☐	☐	☐		$		☐	☐	☐

NOTE: PLEASE INCLUDE COPIES OF ANY DOCUMENTS RECEIVED FROM THESE SOURCES, INCLUDING ANY BENEFIT PAYMENT STATEMENTS.

MANDATORY APPLICATION FOR DIRECT DEPOSIT (IMPORTANT: Please sign the authorization and enclose a cheque specimen marked "VOID").

I hereby authorize SSQ, Life Insurance Company Inc. to deposit my Income Insurance benefit payments into my bank account.

Signature _____ Date (Y Y Y Y M M D D)

I hereby certify that the above information is true, accurate and complete. For the purposes of reviewing my benefit claim, I authorize SSQ, Life Insurance Company Inc. (hereinafter SSQ) to obtain from corporate persons or individuals such as:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer, or the former employer;
- any other insurance or reinsurance companies;
- any public or parapublic organizations body, such as Employment insurance, Worker's compensation or provincial automobile insurance;
- any other person or institution,

personal information on myself, namely medical information.

I hereby authorize the said corporate persons or individuals to disclose to SSQ the requested information and I release them of their liability to confidentiality. I also authorize SSQ to communicate my file to one or several physicians of its choice for evaluation purposes. Copies of this document shall have the same legal value as the original.

Signature _____ Date (Y Y Y Y M M D D)

IMPORTANT

The following sections must be completed and signed:

By the insured

- Statement of Insured (1 to 15)
- Upper part of Statement completed of Attending Physician

By the plan administrator

- Statement of Plan Administrator

You can receive an email at each step of the processing of your disability file.
*Go to **SSQ.CA**, and register for the **ACCESS | Plan Members** Web site to automatically take advantage of this tool!*
Don't forget to provide an email address that you'll have access to during your disability.

Statement of plan administrator

Name of person responsible | Title

Name of group | Telephone | Extension | Group no. | Contract no. | Certificate no. | Certificate no.

Surname of insured | Given name of insured

Has the employee been off work in the past 12 months? ☐ no ☐ yes If so, please specify the period _____

Occupation of insured

Description of insured's tasks

Weekly salary at beginning of disability: Gross $ _____ Net $ _____ (gross salary less federal and provincial income taxes, QPP, and Employment Insurance)

Personal exemptions: Federal TD1 $ _____ Provincial TP1015.3 $ _____

☐ Full-time ☐ Part-tim: % of time worked _____ ☐ On call ☐ Other (specify): _____

Regular work week: from DAY to DAY Workday: from TIME to TIME

Number of hours worked in a regular week: _____ Employment Start Date: Y Y Y Y M M D D

Last day worked: Y Y Y Y M M D D Number of hours worked on this day: _____

Date of first day of absence from work: Y Y Y Y M M D D

Has the employee returned to work? ☐ no ☐ yes → Date: Y Y Y Y M M D D

TO BE COMPLETED FOR EMPLOYEES WITH VARIABLE WORK SCHEDULES

Indicate in the appropriate boxes the number of hours for each day:

1st – As of the last day worked 2nd – On return to work

YEAR	MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Does the disability result from a work-related ☐ accident?
☐ an occupational illness?

Does the disability coincide with:

a dismissal? ☐ no ☐ yes → Date Y Y Y Y M M D D

a lay-off? ☐ no ☐ yes → from Y Y Y Y M M D D to Y Y Y Y M M D D Date of notification Y Y Y Y M M D D

an elimination of a position? ☐ no ☐ yes → Date Y Y Y Y M M D D

an unpaid leave? ☐ no ☐ yes → from Y Y Y Y M M D D to Y Y Y Y M M D D

retirement? ☐ no ☐ yes → Date Y Y Y Y M M D D

other: specify _____ from Y Y Y Y M M D D to Y Y Y Y M M D D

During the period of disability, have you made any payments to this employee? ☐ no ☐ yes

If yes, specify the nature, the period and the amount of any such payments:
(E.g.: holiday, sick-leave)

Nature	Period	Amount

Is there any other information concerning the present claim that we should be aware of? ☐ no ☐ yes

If yes, please specify: _____

If the employee is capable of performing a function with this condition, is there modified work available in your organization presently or in the future? ☐ no ☐ yes

If the employee has performed modified work please provide a description of the duties and applicable dates: _____

I hereby certify that the above information is true, accurate and complete.

Signature of authorized person _____ Date Y Y Y Y M M D D