Claimant's Guide

Disability Insurance

BLUE CROSS®
CANASSURANCE

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IMPORTANT NOTICE

Your claim for disability benefits must be submitted to the Insurer within 90 days of the onset of disability. Any claim received thereafter may be denied.

INTRODUCTION

This guide provides information to help you file a claim for disability benefits and includes the forms to be completed.

On the following three pages, you will find information designed to help you correctly complete the enclosed forms.

On page 5, you will find a list of Frequently Asked Questions. Should you have any additional questions, do not hesitate to contact us directly prior to forwarding your claim to the appropriate address appearing in the box below. By contacting us beforehand, you will avoid any unnecessary delays. Please note that calls to our Claims Department are recorded for training, quality control and verification purposes.

Blue Cross Canassurance
Claims, Life and Disability Insurance

Telephone: 1-800-300-5002
Fax: 1-877-590-7504

Ontario Office
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
Email: claimslife.disability@ont.bluecross.ca

Québec Office
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
Email: claimslife.disability@qc.bluecross.ca

CLAIMANT INFORMATION

Please read these instructions carefully before completing the enclosed forms in order to provide all relevant details.

CLAIMANT'S STATEMENT

It is important to answer all of the questions appearing on this form.

If you have submitted a claim to another insurer or government organization, please attach a copy of the benefits statement or correspondence received from the other insurer or organization. If you have received no response to date, please attach a photocopy of your claim for benefits.

If you are submitting a claim following an accident

The term 'accident' is clearly defined in the General Conditions of your insurance policy. Be advised that neither 'overexertion' nor 'unintended body movement' is generally considered an accident. If you have suffered an accident, it is important to provide a detailed description of the event that resulted in your disability.

AUTHORIZATION

- This section contains six (6) authorization forms which must all be completed, signed and dated. They will be used to obtain the information required to assess your claim for benefits or to disclose information to third parties.
- Read the authorization carefully to be certain that you fully understand the implications of the text.
- An improperly completed or unsigned authorization form could delay the processing of your claim.
- To avoid unnecessary delays, it is preferable to sign each authorization form using a blue ink ballpoint pen. Some hospitals may mistake a form signed using black ink for a photocopy.

REQUEST FOR PAYMENT BY DIRECT DEPOSIT

We recommend that you select direct deposit as your payment method for a number of reasons:

- Avoid the many possible delays that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

To receive payment by direct deposit, simply fill out the form and attach a voided cheque.

EMPLOYMENT INFORMATION

Read these instructions carefully in order to properly complete the required forms. Please make sure that your employer (if applicable) provides all relevant details.

IF YOU ARE CURRENTLY UNEMPLOYED
Please indicate your employment status in the PROFESSIONAL EXPERIENCE section of the CLAIMANT'S STATEMENT form.

EMPLOYER'S STATEMENT
- Complete the IDENTIFICATION section of the form.
- Make sure that your employer completes the remaining sections if you are a salaried or contract employee.
- Attach a job description to your declaration if such a document is available from your employer.
- Attach a copy of your last pay stub prior to the onset of disability.

IF YOU HAVE MORE THAN ONE EMPLOYER
Make sure that each of your employers completes a declaration form.

SELF-EMPLOYED WORKER'S STATEMENT
- Complete this form if you are self-employed, a partner in or principal shareholder/owner of your business.
- If possible, attach a job description.

INCOME INFORMATION

Please submit a copy of your latest Income Tax Return (Pages 1 to 4), as well as the Notices of Assessment received from Canada Revenue Agency and Revenu Québec (if you are a resident of the province of Québec) following the filing of your returns. Self-employed individuals must also attach provincial Form *TP80: Business or Professional Income and Expenses (for Québec's residents)* and the federal Form *T2125 Statement of Business or Professional Activities*.

If you are a majority shareholder and receive income in the form of dividends paid by your company, please include a copy of the company's financial statements for the most recently completed financial year, as well as proof of your shareholding percentage in the company. Please note that dividends are not deemed to be eligible income; rather, we consider the company's profits.

There is no need to submit proof of income if:
- your insured amount is $1,000 or less per month and this amount is guaranteed according to the provisions of your policy;
- you provided proof of income when your policy was issued and the endorsement attached to your policy indicates a minimum amount of income guaranteed by the insurer;
- you subscribed to coverage through a professional association and the benefit amount is established based on the number of children or dependants. In this case, you are required to include a copy of the government-issued form indicating your number of individual beneficiaries.

* Upon analysis of your claim for benefits, proof may be required in certain specific cases.

MEDICAL CONDITION INFORMATION

Please read these instructions carefully as many documents are required. Be sure to include the 'Attending Physician's Statement' and all relevant documents (examination results, clinical notes, etc.).

ATTENDING PHYSICIAN'S STATEMENT

- Complete only the IDENTIFICATION section of this form.
- Make sure that your doctor completes the ATTENDING PHYSICIAN'S STATEMENT section.
- Based on the nature of your medical condition, the attending physician must complete either the PHYSICAL ILLNESS or PSYCHOLOGICAL ILLNESS section, or both, as the case may be.
- A photocopy of clinical notes, medical test results and reports from any medical specialist consulted must accompany the form completed by your physician. Some physicians charge a fee to complete this form and provide copies of relevant documents. Please note that these fees are the claimant's responsibility.

IMPORTANT

Do not write anything on or amend notes made by your doctor on the ATTENDING PHYSICIAN'S STATEMENT. If you wish to amend or comment on the information provided by your physician, please do so on a separate sheet of paper. You may use one of the sheets entitled '**Notes**' found at the end of this Guide.

FREQUENTLY ASKED QUESTIONS

1. What is a waiting period?

A waiting period is the number of days of total disability during which no benefit is payable by the insurer. This waiting period is set out in the contract summary on the first page of your policy. Please consult your policy for further details.

2. What is a pre-existing condition?

Insurance policies issued without a prior medical examination are subject to exclusions relating to pre-existing medical conditions. A pre-existing condition is a medical condition that you suffered from prior to the effective date of your policy. This condition is excluded for a certain period of time, generally 12 months. Please consult your policy for further details.

Whenever a claim for a disability which began during an exclusion period is presented, we must verify your medical history. This may delay the decision made with respect to your claim as we must contact your provincial health insurance board and previously consulted physicians. If such a delay occurs, we will advise you promptly.

3. What is 'incontestability'?

The majority of insurance policies are issued based on medical information provided during the application process. Whenever a claim for a disability which began within two (2) years of the effective date of your policy is presented, we must verify your medical history to confirm the accuracy of the information declared on the application form. This may result in a lengthy delay in the assessment of your file since we must contact your provincial health insurance board and all previously consulted physicians. If such a delay occurs, we will advise you promptly.

4. Why am I required to provide a copy of my income tax returns?

Disability benefits serve to compensate for lost income. Policies generally stipulate that non-taxable benefits must not exceed the net income earned prior to the onset of a disability. Therefore, we require a copy of your latest Income Tax Returns, and the Notices of Assessment issued by Canada Revenue Agency and Revenu Québec (if you are a resident of the province of Québec).

For further details on how payable benefits are calculated, please refer to your insurance policy.

5. Am I required to continue paying my premiums?

Yes, you must continue to pay your premiums. If the insurer recognizes your disability and the terms of your policy provide for a waiver of premiums for certain benefits, you may be entitled to a premium holiday following the waiting period as per the terms of your policy. Any overpaid premiums would then be reimbursed. For further details on premium waivers, please refer to your insurance policy.

6. What happens once I have mailed in my claim for benefits?

Upon receipt of your claim, an acknowledgement will be sent to you. A file will be opened and transferred to an analyst along with all documents received.

If further information or documents are required to complete your file, you will be advised accordingly. To the extent possible, we will contact you by telephone to request additional information, discuss your claim and answer any questions you may have.

It is possible that additional information will be requested from your physician or other professionals. We may also request that an independent physician or rehabilitation expert evaluate your condition to better understand your situation.

7. What if I am not able to sign my claim form?

If you are unable to sign your claim form, your Power of Attorney may sign on your behalf. Please be advised that we will not release any information regarding your claim to your Power of Attorney until he or she provides us with a notarized document.

8. What can I do to speed up the claim process ?

Your must answer every question and sign the Claimant Statement as well as the Authorization forms. Make sure to attach a copy of your medical file (including your doctor's notes) to the Physician statement. Your physician's secretarial service should provide you with these documents. Consult the list of required documents at the last page of this guide to ensure that your file is complete and ready to be processed.

9. Is my claim automatically accepted?

The decision to approve disability benefits and to continue or terminate the payment of such benefits is based on your health condition and the definition of disability provided by your policy. This decision is subject to benefit termination clauses, limitations, exclusions and other provisions set out in the policy (pre-existing conditions, incontestability, etc.).

If your claim is approved, you must receive the medical care required for your condition and have regular follow-ups with your physician in accordance with the provisions of your policy. It is important to provide us with medical proof and to advise us of any changes in your treatment or your medical condition during the disability period.

If your claim is denied, we will detail the reasons justifying our decision.

10. My claim has been denied. May I request a reassessment?

Yes. In many cases, claims are denied because the file is incomplete. To avoid delays, please make sure to attach all required forms and documents before sending your claim. Use the checklist appearing on the back of this guide.

If your claim is denied, you will be advised in writing. You will need to provide the additional documents or information requested for the revision of your file.

If you have provided all of the requested documents and your claim is still denied, you may appeal to the Claims Management at the appropriate address appearing on page 1 of this guide.

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Claimant's Statement

IDENTIFICATION

Claimant's Name: _____ Policy No: _____

Date of Birth: _____ day / month / year _____ Social Insurance No: _____ Public Health Card No: _____

Address: _____

Home Phone: _____ Mobile: _____ E-mail: _____

MEDICAL INFORMATION

1. Height: _____ ❑ in feet & inches ❑ in meters Weight: _____ ❑ in lbs ❑ in kg ❑ left-handed ❑ right-handed

2. Do you wear: ❑ glasses ❑ contact lenses
   If so, do you wear them: ❑ all the time ❑ for driving only ❑ for reading only

3. What is the cause of your disability? ❑ illness ❑ accident ❑ occupational illness* ❑ workplace accident* ❑ vehicle accident*
   *** If your disability is caused by occupational illness, vehicle accident or accident in the workplace, please attach the claim made to a provincial workers' compensation board or other relevant organization (WSIB, WCB, CNESST etc.). A copy of all correspondence with these organizations will also be required.**

4. For an illness, please indicate the date on which symptoms first appeared: _____ day / month / year _____

5. For an accident, please provide as much information as possible.
   Date: _____ day / month / year _____ Time: _____

   Location of accident (Indicate, if possible, street address and type of location: residence, public building, roadway, job site, etc.):

   _____

   _____

   Circumstances surrounding the accident (Explain how the accident occurred): _____

   _____

   _____

   Name(s) of witnesses: _____

   _____

   Was a police report produced? ❑ yes ❑ no If yes, please attach a copy to your claim.

6. Are you pregnant? ❑ not applicable ❑ yes ❑ no If yes, indicate expected date of delivery: _____ day / month / year _____

7. Date of last day worked: _____ day / month / year _____ Date of onset of disability (inability to work): _____ day / month / year _____

8. Date of first visit with physician for this condition: _____ day / month / year _____

9. Other medical consultations since beginning of sick leave : _____

   _____

10. Date of return to work: _____ day / month / year _____

11. Did you undergo or are you waiting for tests, treatment, consultations or surgery? ❑ yes ❑ no If yes, please specify: _____

    _____

12. Were you hospitalized for this condition? ❑ yes ❑ no
    If yes, where? _____ Duration of hospitalization: from _____ day / month / year _____ to _____ day / month / year _____

MEDICAL HISTORY INFORMATION

1. Please indicate the names, specialties and addresses of physicians consulted in the past 5 years as well as the drugstores where you purchased your medication during this period.

Name	Speciality	Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Please provide the requested information on medication taken and treatments undergone in the past year:

Name of medication or treatment	Date:	Reason for medication or treatment
_____	day / month / year	_____
_____	day / month / year	_____
_____	day / month / year	_____
_____	day / month / year	_____

PHYSICAL ABILITY INFORMATON

Please describe the impact of your accident or illness on your ability to carry out the following activities. Indicate the time in minutes during which you were able to carry out each activity before and after your disability.

Activity	Ability **before** disability (in minutes)	Ability **since** disability (in minutes)	Did you change how you carry out this activity?
Walk			❑ yes ❑ no
Run			❑ yes ❑ no
Remain standing			❑ yes ❑ no
Remain seated			❑ yes ❑ no
Climb up stairs			❑ yes ❑ no
Climb down stairs			❑ yes ❑ no

SOURCE OF INCOME INFORMATION

Please submit a copy of your latest Income Tax Returns, as well as Notices of Assessment received from Canada Revenue Agency and Revenu Québec (for resident of province of Québec only) for the year preceding your work stoppage, as well as a copy of your last pay stub.

Have you or are you planning to present a claim under one of the following plans or to one of the following organizations? ❑ yes ❑ no
Please enclose a copy of statements with your claim or forward them to us as soon as possible.

		Benefit Amount	Benefit Frequency
Employment Insurance Canada	❑ yes ❑ no	$_____	per _____
Workers' compensation board	❑ yes ❑ no	$_____	per _____
Public or private automobile insurance	❑ yes ❑ no	$_____	per _____
Criminal Injuries Compensation Program	❑ yes ❑ no	$_____	per _____
Canada Pension Plan	❑ yes ❑ no	$_____	per _____
Québec Pension Plan	❑ yes ❑ no	$_____	per _____
Private or public pension plan	❑ yes ❑ no	$_____	per _____
Loan insurance (mortgage, automobile, personal loan)	❑ yes ❑ no	$_____	per _____
Other salary insurance policy (individual, group, professional association)	❑ yes ❑ no	$_____	per _____
Other government program (QPIP, Veterans, CARRA, etc.)	❑ yes ❑ no	$_____	per _____

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Claimant's Statement

EDUCATION INFORMATION

1. Level completed: ❑ Primary ❑ Secondary ❑ Vocational training ❑ College ❑ University
2. Last completed degree (specify): _____
3. In which field? _____
4. Other proficiency courses: _____
5. Languages spoken: ❑ English ❑ French ❑ Other _____
6. Languages written: ❑ English ❑ French ❑ Other _____
7. IT knowledge: ❑ Internet ❑ Word processing ❑ Spreadsheet software ❑ Other_____

EDUCATION INFORMATION

1. Did you occupy a gainfully employed position at the time of your disability? ❑ yes ❑ no
   If no, for how long had you been unemployed? _____
   If yes, what is your current position? _____
2. For how many years have you worked in this position? _____
   _____
3. Brief description of your tasks: _____
   _____
   _____
   _____
   _____
4. At the time of your sick leave, did you have a second employer? ❑ yes ❑ no
   If yes, please provide name of employer: _____
5. Position occupied: _____ Since: _____
6. Brief description of your tasks: _____
   _____
   _____
   _____
   _____
7. What was your previous job? _____
8. For how many years did you work in this position? _____
9. List other jobs occupied over the course of your career, with the number of years at each:

_____ _____ years
Job

_____ _____ years
Job

_____ _____ years
Job

_____ _____ years
Job

_____ _____ years
Job

LEISURE ACTIVITY INFORMATION

Please list the leisure/sporting activities in which you engaged prior to your illness or accident and the impact of your disability on each.

Leisure/sporting activity or hobbies	Number of hours per week prior to disability	Number of hours per week after disability

DAILY ACTIVITY INFORMATION

Please check the activities that you can no longer engage in as a result of your accident or illness.

Activity	Did you engage in this activity prior to your disability?	Have you engaged in this activity since your disability?	Have you changed how you engage in this activity?
Prepare meals	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Wash dishes	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Drive a vehicle	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Take the bus	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Sweep	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Use the vacuum cleaner	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Do the laundry	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Take out the garbage	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Make the bed	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Shovel snow	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Cut the grass	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Do the grocery shopping	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Shop	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Outings (cinema, concerts, etc.)	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Watch television	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Read (newspaper, magazine, book)	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Play games (cards, checkers, etc.)	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Manage the budget	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no

OTHER INFORMATION

1. Are you licensed to drive a vehicle? ❑ yes ❑ no If yes, indicate permit class: _____
2. Has your licence been suspended? ❑ yes ❑ no If yes, for how long: _____
3. For what reason? _____

DECLARATION

I hereby certify that the above information is, to the best of my knowledge, true and complete.

Signature of claimant: _____ Date: _____ day / month / year

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

Name of claimant: _____

Policy No: _____ Date of birth: _____ day / month / year

Name of policyholder: _____

To assess and determine my eligibility with respect to insurance products and benefits, I hereby authorize any physician, health professional, hospital, medical establishment, insurance company or reinsurer, the Medical Information Bureau (MIB) or other organization, institution, employer, broker, agent, representative or other individual in the possession of information about me or my state of health, including my medical history, to convey or transmit this information to Canassurance Hospital Service Association or Canassurance Insurance Company (hereinafter referred to as the 'Insurer'), or reinsurer, internal or external auditors, as well as any professional or organization mandated by the Insurer for the purpose of processing of my claim.

I hereby authorize Canada Pension Plan (CPP), Québec Pension Plan (QPP), Human Resources and Skills Development Canada (HRSDC), *Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)*, Workplace Safety and Insurance Board of Ontario (WSIB), *Régie de l'assurance maladie du Québec (RAMQ)*, *Société de l'assurance automobile du Québec (SAAQ)* and any other federal or provincial organization or board to convey to the Insurer administrative, medical and pharmacological information about me.

In addition, I hereby authorize the Insurer to share information about me with the aforementioned individuals and organizations. This authorization shall be valid for the duration of my disability claim.

_____ _____ day / month / year

Signature of claimant Date

_____

Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

Name of claimant: _____

Policy No: _____ Date of birth: _____ day / month / year

Name of policyholder: _____

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11QRI0002A (2020-05)

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

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Name of policyholder: _____

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_____ _____ day / month / year

Signature of claimant Date

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_____ _____ day / month / year

Signature of claimant Date

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Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec

11QRI0002A (2020-05)

BLUE CROSS® CANASSURANCE

Request for Payment by Direct Deposit

IDENTIFICATION

Name of claimant: _____ Policy No: _____

BANK ACCOUNT DETAILS

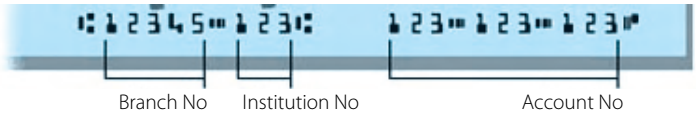
Name of financial institution: _____

Branch address: _____

_____

Branch No _____ Institution No _____ Account No _____

These numbers appear at the bottom of your cheque.
Please indicate all account/folio number digits, including zeroes (0s).



I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of claimant: _____ Date : _____day / month / year_____

We recommend that you select direct deposit for a number of reasons:
- Avoid the many possible delays that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Please attach a VOIDED and unsigned cheque to this form.

BLUE CROSS® CANASSURANCE

Employer's Statement

IDENTIFICATION

Name of Employee: _____

Policy No: _____ Social Insurance No: _____

EMPLOYEE INFORMATION

1. Employee's date of hire: _____
2. Employee's status ❑ permanent ❑ temporary ❑ seasonal ❑ part-time ❑ contractual
3. Number of regular hours worked per week: _____
4. Seasonal employees – number of weeks per year: Check months normally worked:
   ❑ January ❑ February ❑ March ❑ April ❑ May ❑ June ❑ July ❑ August ❑ September ❑ October ❑ November ❑ December
5. Gross salary: $ _____ Pay periods per year: ❑ 52 ❑ 26 ❑ 24 ❑ 12
   CPP/QPP contribution: $ _____ CEIC contribution: $ _____ QPIP contribution: $ _____
   Federal income tax: $ _____ Provincial income tax: $ _____
6. Employee position title: _____
7. Number of years in this position? _____
8. Briefly describe this employee's responsibilities: _____
   _____
9. Is this employee covered under a group or personal insurance plan to which the company subscribes or contributes?
   ❑ yes ❑ no If yes, please provide the following information:
   Name of Insurer: _____
   Group No (if applicable): _____ Certificate or Policy No: _____
10. Do you pay a portion of the Blue Cross personal insurance premium? ❑ yes ❑ no

SICK LEAVE INFORMATION

1. Date of last day worked by employee: _____ day / month / year
2. Date of last day paid by employer: _____ day / month / year
3. On the date of onset of disability, was the employee: on holiday, laid off, unpaid leave or disciplinary suspension?
   ❑ yes ❑ no If yes, please specify: _____
   _____
4. Have the responsibilities of this employee been modified recently? ❑ yes ❑ no
   If yes, please specify: _____
   _____
5. Had you noticed any change in employee performance or attendance prior to the onset of disability? ❑ yes ❑ no
   If yes, please specify: _____
6. Was the disability caused by an accident in the workplace or occupational illness? ❑ yes ❑ no
   If yes, has the employee presented a claim to CNESST, WSIB or other workmen's compensation board? ❑ yes ❑ no
   If yes, please attach a copy of the claim and any related correspondence with the organization(s).
7. If necessary, could you offer: a) a gradual return to work? ❑ yes ❑ no b) lighter duties? ❑ yes ❑ no
8. Expected date of return to work: _____ day / month / year
9. If employee has already returned to work, please specify date: _____ day / month / year
10. Do you have any doubts about the validity of this claim? ❑ yes ❑ no

IMPORTANT: PLEASE COMPLETE REVERSE OF THIS FORM

WORKING ENVIRONMENT INFORMATION – Is this employee exposed to one or other of the following? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Noise							
Dust							
Vibration							
Outdoor work							
Hazardous machinery							
Hazardous products							
Other (Please specify) _____							

PHYSICAL EFFORT INFORMATION – To what extent must this employee do as follows? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Position							
Sit							
Stand							
Walk							
Crouch on knees							
Crawl							
Stretch arms above shoulder height							
Stretch arms below shoulder height							
Climb up and down stairs							
Effort							
Lift up							
Push							
Raise							
Pull							
Move objects							
Conduct repetitive movements							

Can this employee change position if needed? ❑ yes ❑ no

Percentage of time per day: sitting: _____ % standing: _____ % walking: _____ %

Is this employee required to lift heavy objects? ❑ yes ❑ no

Maximum weight is normally:

❑ 0 - 5 ❑ 10 - 15 ❑ 20 - 25 ❑ 30 - 35 ❑ 40 - 45 ❑ 50 and over (❑ pounds or ❑ kilograms)

If this employee's work involves repetitive movement, please specify: _____

Percentage of total working time: _____ %

Limb(s) solicited: _____

_____

Repetitive movement with: ❑ dexterity (e.g.: keyboard speed) or ❑ physical effort (e.g.: assembly line)

Pace is: ❑ fixed (e.g.: feed machine) or ❑ variable

PSYCHOLOGICAL EFFORT DETAILS – To what extent must this employee resort to? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Memory and comprehension							
Sustained concentration							
Social interaction							
Adaptation							

STATEMENT

I hereby certify that the information provided hereinabove is, to the best of my knowledge, true and complete.

Name of company: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____ E-mail: _____

Name of signatory: _____ Title: _____

Signature: _____ Date: _____ day / month / year

BLUE CROSS® CANASSURANCE

Self-Employed Worker's Statement

IDENTIFICATION

Name of Claimant: _____

Policy No: _____ Social Insurance No: _____

WORK INFORMATION

1. What is the nature of your profession/work? _____
2. How long have you been self-employed in this capacity? _____
3. Number of hours worked per week: _____
4. Do you work all year? ❑ yes ❑ no If you answered no, please check the months that you normally work:
   ❑ January ❑ February ❑ March ❑ April ❑ May ❑ June ❑ July ❑ August ❑ September ❑ October ❑ November ❑ December
5. Do you work from home? ❑ yes ❑ no
   If yes, please specify:
   a) number of hours per day _____ per week _____
   b) if your office accessible to public: ❑ yes ❑ no
   c) if employees (not family members) work in this office: ❑ yes ❑ no
6. Do you contribute to the following?:
   Employment insurance ❑ yes ❑ no CNESST/WSIB/WCB ❑ yes ❑ no CPP/QPP ❑ yes ❑ no QPIP ❑ yes ❑ no
7. Date of last day worked: _____ day / month / year _____
8. Who is substituting for you during your disability?
   ❑ partner/shareholder ❑ employee ❑ contracts transferred to other company ❑ other: _____

COMPANY INFORMATION

1. Name of company: _____
2. Address: _____
3. Tel No: (_____) _____ Fax No: (_____) _____
4. E-mail: _____
5. Website: _____
6. Nature of company: _____
7. Type of legal entity:
   ❑ sole proprietorship ❑ general partnership ❑ incorporated business or company
8. Total number of partners or shareholders: _____
9. Percentage of shares held in company or percentage holding of general partnership: _____
10. Number of full time employees (excluding shareholders and members): _____
11. Number of part time employees (excluding shareholders and members): _____

RESPONSIBILITY INFORMATION

Please detail your responsibilities and the percentage of time devoted to each prior and subsequent to your disability:

Responsibilities	% of time prior to disability	% of time since disability
Manual labour		
Management – office work		
Sales – solicitation		
Employee supervision		
Other (Please specify)		

IMPORTANT: PLEASE COMPLETE REVERSE OF THIS FORM

WORKING ENVIRONMENT INFORMATION – Are you exposed one or other of the following? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Noise							
Dust							
Vibration							
Outdoor work							
Hazardous machinery							
Hazardous products							
Other (Please specify) _____							

PHYSICAL EFFORT INFORMATION – To what extent must you do as follows? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Position							
Sit							
Stand							
Walk							
Crouch on knees							
Crawl							
Stretch arms above shoulder height							
Stretch arms below shoulder height							
Climb up and down stairs							
Effort							
Lift up							
Push							
Raise							
Pull							
Move objects							
Conduct repetitive movements							

Can you change position if needed? ❑ yes ❑ no

Percentage of time per day: sitting: _____ % standing: _____ % walking: _____ %

Are you required to lift heavy objects? ❑ yes ❑ no

Maximum weight is normally:
❑ 0 - 5 ❑ 10 - 15 ❑ 20 - 25 ❑ 30 - 35 ❑ 40 - 45 ❑ 50 and over (❑ pounds or ❑ kilograms)

If your work involves repetitive movement, please specify: _____

Percentage of total working time: _____ %

Limb(s) solicited: _____

_____

Repetitive movement with: ❑ dexterity (e.g.: keyboard speed) or ❑ physical effort (e.g.: assembly line)

Pace is: ❑ fixed (e.g.: feed machine) or ❑ variable

PSYCHOLOGICAL EFFORT INFORMATION – To what extent must you resort to (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Memory and comprehension							
Sustained concentration							
Social interaction							
Adaptation							

STATEMENT

I hereby certify that the information provided hereinabove is, to the best of my knowledge, true and complete.

Signature of the insured: _____ Date: _____ day / month / year

BLUE CROSS® CANASSURANCE

Attending Physician's Statement

Psychological Illness

For physical illness, please complete the other side of this form.

IDENTIFICATION OF PATIENT (Section to be completed by claimant)

Surname: _____ First Name: _____ Date of Birth: _____

Policy No: _____ Public Health Insurance No: _____

DECLARATION OF ATTENDING PHYSICIAN (Please print in block letters and remit to patient)

1. DIAGNOSIS

1.1. Primary: _____ Code CIM-9 : _____

1.2. Secondary: _____ Code CIM-9 : _____

1.3. Current symptoms: _____

1.4. Degree of gravity of all symptoms combined: ❑ mild ❑ moderate ❑ severe ❑ with psychotic elements

1.5. Does work stoppage owe to difficulties relating to:
❑ marital/family life ❑ job loss or layoff ❑ occupational problems ❑ personal/interpersonal problems
❑ abusive consumption of alcohol/drugs or gambling problems
❑ other, please specify: _____

1.6. For this/these illness(es) or the symptoms associated with this diagnosis, has this patient previously:
❑ received medical treatment ❑ consulted another physician ❑ taken medication ❑ been hospitalized ❑ undergone examination
Please specify date(s) of previous episode(s): _____

2. TREATMENT

2.1. Medication - name- dosage: _____

_____

2.2. Is the patient consulting: a psychiatrist? ❑ no ❑ yes a social worker? ❑ no ❑ yes
a psychologist? ❑ no ❑ yes another health sector worker? ❑ no ❑ yes
If yes, name of health sector worker consulted: _____

2.3 Hospitalization: from _____ to _____ Name of hospital: _____

3. FOLLOW-UP AND PROGNOSIS

3.1. Date of initial consultation for this condition: _____ Date of next consultation: _____

3.2. Other consultation dates: _____

3.3. Frequency of follow-up: _____

3.4. Will patient be referred to a psychiatrist? ❑ no ❑ yes Name of physician: _____

3.5. Approximate duration of disability: _____ days _____ weeks ❑ To be determined or date of return to work: _____

3.6. When will this patient be able to return to work? _____ days _____ weeks
❑ part time ❑ full time ❑ gradual return Please specify: _____

Please attach a copy of your clinical notes and any investigative reports completed since the onset of disability.

4. COMMENTS

Please add any comment that would help us better understand your patient's medical condition.

_____

_____

_____

STATEMENT

Surname and first name: _____ Telephone: _____

Address: _____ Fax: _____

❑ General practitioner ❑ Specialist Please specify: _____ Licence No: _____

Signature: _____ Date: _____ day / month / year

Note: The claimant must pay any fees requested to complete this form.

BLUE CROSS® CANASSURANCE

Attending Physician's Statement

Physical Illness

For psychological illness, please complete the other side of this form.

IDENTIFICATION OF PATIENT (Section to be completed by claimant)

Surname: _____ First Name: _____ Date of Birth: _____

Policy No: _____ Public Health Insurance No: _____

DECLARATION OF ATTENDING PHYSICIAN (Please print in block letters and remit to patient)

1. DIAGNOSIS

1.1. Primary: _____ Code CIM-9 : _____

1.2. Secondary: _____ Code CIM-9 : _____

1.3. Current symptoms: _____

1.4. For this/these illness(es) or the symptoms associated with this diagnosis, has this patient previously:
❑ received medical treatment ❑ consulted another physician ❑ taken medication ❑ been hospitalized ❑ undergone examination
Please specify date(s) of previous episode(s) _____

1.5. Does this condition relate to: ❑ an accident ❑ an illness ❑ an accident in the workplace ❑ an automobile accident
Date of event: _____
A pregnancy ❑ no ❑ yes
Preventive withdrawal from workplace ❑ no ❑ yes Expected delivery date: _____

1.6. Describe the functional limitations which prevent this patient from carrying out his/her responsibilities or normal activities:

At onset of disability	Presently
_____	_____
_____	_____
_____	_____

2. TREATMENT

2.1. Medication – name and dosage: _____

2.2. Date medication started: _____

2.3 Is this patient scheduled to:
a) undergo testing? ❑ no ❑ yes Specify _____
b) undergo surgery? ❑ no ❑ yes Name of surgical procedure: _____
Is it a one-day surgery? ❑ no ❑ yes Date or planned date of surgery: _____
c) undergo other treatments ? ❑ no ❑ yes Specify: _____
d) be hospitalized? Hospitalization: from _____ to _____ Name of hospital: _____
e) undergo a short stay for observation purposes (number of hours)? _____

3. FOLLOW-UP AND PROGNOSIS

3.1. Date of initial consultation for this condition: _____ Date of next consultation: _____

3.2. Other consultation dates: _____

3.3. Referral to another physician? ❑ no ❑ yes Name of physician: _____ Specialty: _____

3.4. Approximate duration of disability: _____ days _____ weeks ❑ To be determined or date of return to work: _____

3.5. When will this patient be able to return to work? _____ days _____ weeks
❑ part time ❑ full time ❑ gradual return Please specify: _____

Please attach a copy of your clinical notes and any investigative reports completed since the onset of disability.

4. COMMENTS

Please add any comment that would help us better understand your patient's medical condition.

_____

_____

STATEMENT

Surname and first name: _____ Telephone: _____

Address: _____ Fax: _____

❑ General practitioner ❑ Specialist Please specify: _____ Licence No: _____

Signature: _____ Date: _____ day / month / year

Note: The claimant must pay any fees requested to complete this form.

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Notes

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Notes

Have you enclosed the following documents?

- ❑ Claimant's Statement
- ❑ Authorization forms signed and dated
- ❑ Request for Payment by Direct Deposit and voided cheque
- ❑ Attending Physician's Statement and medical file
- ❑ Employer's Statement or Self-Employed Worker's Statement
- ❑ Income tax returns, notices of assessment, pay stub(s), financial statements

For any questions, please contact our Claims Department directly.

Blue Cross Canassurance
Claims, Life and Disability Insurance

Telephone: 1-800-300-5002
Fax: 1-877-590-7504

Ontario Office
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
Email: claimslife.disability@ont.bluecross.ca

Québec Office
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
Email: claimslife.disability@qc.bluecross.ca

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