MUTUAL

# REQUEST FOR DISABILITY BENEFITS

## GROUP INSURANCE

**IMPORTANT :** AS SOON AS AN EMPLOYEE IS ABSENT FROM WORK ANS IS ELIGIBLE FOR DISABILITY BENEFITS, OR QUALIFIES FOR WAIVER OF PREMIUM, PLEASE TRANSMIT THIS FORM TO THE INSURER IMMEDIATELY. ANY INITIAL REQUEST SHOULD INCLUDE AN EMPLOYER'S DECLARATION, EMPLOYEE'S DECLARATION AND ATTENDING PHYSICIAN'S STATEMENT DULY COMPLETED AND SIGNED.

## EMPLOYEE'S DECLARATION

| GROUP | DIVISION | CLASS | **CERTIFICATE** |
|---|---|---|---|
| NAME OF EMPLOYEE | SURNAME | | DATE OF BIRTH D M Y |
| ADDRESS | | | |
| CITY | PROVINCE | | POSTAL CODE |
| TELEPHONE NUMBER AREA CODE | NATURE OF DISABILITY | | |

WHEN WERE YOU UNABLE TO WORK DUE TO YOUR DISABILITY? D M Y

DATE YOU CONSULTED A DOCTOR FOR THE FIRST TIME AFTER YOU HAVE STOPPED WORKING D M Y

NAME OF PHYSICIAN

_____

WHEN DO YOU EXPECT TO RETURN TO WORK? D M Y

WERE YOU HOSPITALISED? YES ☐ NO ☐ IF YES, DURING WHAT PERIOD : FROM _____ TO _____

NAME OF HOSPITAL

_____

IS YOUR DISABILITY CAUSED BY AN ACCIDENT? YES ☐ NO ☐

IF YES, WHEN DID THE ACCIDENT TAKE PLACE? D M Y HOUR _____ A..M. ☐ P.M. ☐

WHERE DID THE ACCIDENT TAKE PLACE?

_____

DESCRIBE THE CIRCUMSTANCES OF THE ACCIDENT :

_____

_____

DO YOU RECEIVE ANY OTHER DISABILITY BENEFITS? YES ☐ NO ☐

IF YES, FROM WHICH SOURCE? _____ SINCE WHAT DATE _____

| HAVE YOU SUBMITTED A CLAIM TO ANY OTHER SERVICE SUCH AS : | CLAIM SUBMITTED | DATE | ACCEPTED - REFUSED | | AWAITING RESPONSE |
|---|---|---|---|---|---|
| CANADA PENSION PLAN | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |
| QUEBEC PENSION PLAN | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |
| EMPLOYMENT INSURANCE AND IMMIGRATION CANADA | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |
| WORKERS' COMPENSATION BOARD | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |
| SOCIÉTÉ DE L'ASSURANCE AUTOMOBILE DU QUÉBEC (S.A.A.Q.) | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |
| ANY OTHER ORGANISM OR INSURER | YES ☐ NO ☐ | _____ | ☐ | ☐ | ☐ |

PLEASE ATTACH TO THIS DOCUMENT A COPY OF DOCUMENTS RELATING TO THE CLAIM ACCEPTATION OR REFUSAL, WHATEVER THE CASE.

## AUTHORIZATION

I CERTIFY THAT THE FOREGOING INFORMATION IS ACCURATE AND COMPLETE AND AUTHORIZE ANY DOCTOR, HOSPITAL, CLINIC. INSURANCE COMPANY OR OTHER ORGANISM, INCLUDING WORKERS' COMPENSATION BOARD, S.A.A.Q. AND EMPLOYMENT INSURANCE AND IMMIGRATION CANADA OR ANY OTHER INSTITUTION OR PERSON IN CUSTODY OF A FILE OR PERSONAL INFORMATION OR ON MY HEALT CONDITION TO TRANSMIT TO **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)**, ANY INFORMATION ON MY HEALT CONDITION AND MY MEDICAL HISTORY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

| X | | X |
|---|---|---|
| **DATE** | **NAME OF INSURED (PRINT)** | **SIGNATURE** |