AGA BENEFIT SOLUTIONS

WEEKLY INDEMNITY CLAIM FORM
SELF-INSURED PLAN
INSURED'S DECLARATION

3500 de Maisonneuve Blvd West, Suite 2200, Westmount QC H3Z 3C1

Could be sent par e-mail or fax

- ⇨ **You must submit your claim within 31 days of the beginning of your disability**
- ⇨ **The patient must pay the fees requested by the physician to complete the claim form**
- ⇨ **Any claims that are incomplete may incur delays**
- ⇨ **You must inform your employer of the date you intend to return to work**

E-mail: salaire@aga.ca
Fax : 514 935-1147

Last name : _____ First name : _____ Date of birth : Year Month Day

Contract No. : _____ Group/Division No. : _____ Certificate No. : _____

Address : _____ City: _____ Postal code : _____

Telephone No. : (_____) _____ Occupation : _____

Your social insurance number is required only if the plan benefits are taxable.
The S.I.N. is used solely for issuing T4A and Releve 1 receipts. Social insurance No. : _____

☐ **YES, I would like to receive my weekly indemnity of salary directly into my bank account.**
(Please take note if we don't receive this banking information, your weekly indemnity payment will be sent by check)
It is the responsibility of the member to ensure the accuracy of the banking information entered on the Enrolment form.
If banking information is incorrect, please note that none other than the insured will be held responsible for amounts not received by the member.

Branch	Bank	Account number

1. INFORMATION ON DISABILITY

1.1 Date of last day at work : Year Month Day Date of first consultation with a physician : Year Month Day

1.2 Is the disability result of :

☐ a sickness – Indicate the date on which the first symptoms appeared : Year Month Day

Have you ever been treated for the same illness? No ☐ Yes ☐ If yes, when? _____

☐ an accident ☐ an occupational accident ☐ an automobile accident – Indicate date of the accident : Year Month Day

Place and circumstances of the accident (how it happened) : _____

_____

_____

☐ a pregnancy ☐ a preventive withdrawal from work – Indicate the scheduled date of delivery : Year Month Day

1.3 At the beginning of disability, did you have another occupation (secondary occupation)? No ☐ Yes ☐

1.4 Have you since returned to work? No ☐ Yes ☐ If not, when will you be able to return to work? Year Month Day

2. OTHER BENEFITS

2.1 Have you applied for benefits under any of the following programs or plans ?

	NO	IF YES		IF REFUSED	
		Under study	Accepted	Refused	Do you intend to contest this decision? Yes	No
PROGRAMS Employment Insurance (EI) If yes, date payment of benefits began : Year Month Day	☐	☐	☐	☐	☐	☐
Commission de la santé et de la sécurité du travail (CSST)	☐	☐	☐	☐	☐	☐
Compensation of victims of crime (CVC)	☐	☐	☐	☐	☐	☐
Société de l'assurance automobile du Québec (SAAQ)	☐	☐	☐	☐	☐	☐
PLANS Quebec Pension Plan (QPP) or Canada Pension Plan (CPP)	☐	☐	☐	☐	☐	☐
Commission administrative de régimes de retraite et d'assurances (CARRA)	☐	☐	☐	☐	☐	☐
Private pension plan	☐	☐	☐	☐	☐	☐
Any other group insurance plan : _____	☐	☐	☐	☐	☐	☐

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

3. MEDICAL AUTHORIZATION

I authorize AGA Financial Group Inc. (AGA Benefit Solutions) or my insurer to obtain from any licensed physician, any health care professional or any rehabilitation worker, as well as any public or private health care establishment, any government organization involved with offering health care or social services and any insurer, the medical and administrative informations necessary to process the present weekly indemnity claim. I also authorize AGA Financial Group Inc. (AGA Benefit Solutions) or my insurer to release and exchange these informations with the above-mentioned parties when deemed necessary in the course of their activities or in the processing of my file. I also authorize AGA Financial Group Inc. (AGA Benefit Solutions) to share all information on this form or all information related to my weekly indemnity claim with ACCLAIM, disability management services' provider. A copy of this authorization shall be as valid as the original.

Signature : _____ Date : Year Month Day