

To be sent by e-mail or fax

In the event that Weekly Indemnity is not a benefit covered under your Group Insurance plan, but an insured may have the right to disability benefits covered by Long Term Disability, or through an Industrial Accident and Occupational Hazard Program, or an Indemnity Program related to a car accident, please complete this form and forward it to AGA.

**For more information :**  
**Montreal :** 514 935-5444  
**Elsewhere in Qc :** 1 800 363-6217  
**Fax :** 514 935-1147  
**E-mail:** [salaire@aga.ca](mailto:salaire@aga.ca)

### 1. GENERAL INFORMATION

Employer/Policyholder name : \_\_\_\_\_

Administrator's name : \_\_\_\_\_ Telephone No. : \_\_\_\_\_

Contract No. : \_\_\_\_\_ Group/Division No. : \_\_\_\_\_

Insured's last name : \_\_\_\_\_ First name : \_\_\_\_\_

Certificate No. : \_\_\_\_\_ Date of birth : \_\_\_\_\_

Gross weekly salary : \_\_\_\_\_ Date salary came into effect : \_\_\_\_\_

Date of employment : \_\_\_\_\_ Regular schedule of work : Days : from \_\_\_\_\_ to \_\_\_\_\_ Hours : from \_\_\_\_\_ to \_\_\_\_\_

### 2. INFORMATION ON DISABILITY

2.1 Date of first day of absence from work : \_\_\_\_\_ Last paid workday : \_\_\_\_\_

2.2 Is this person still considered in your employ ? No  Yes

2.3 At the beginning of the disability, insured : was working full-time  was working part-time  has been laid-off  was on a leave of absence

If laid-off or on a leave of absence, date of beginning : \_\_\_\_\_<sup>Day</sup> Reason : \_\_\_\_\_

2.4 Nature of sickness or injuries sustained : \_\_\_\_\_

2.5 Is this a case concerning : C.S.S.T. (Commission de la santé et sécurité du travail)  S.A.A.Q. (Société de l'assurance automobile du Québec)

C.V.C. (Compensation for victims of crime)

2.6 If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the C.S.S.T. ? No  Yes

Scheduled date of the maternity leave : \_\_\_\_\_ Scheduled date of delivery : \_\_\_\_\_

2.7 Are there circumstances that lead you to doubt the validity of the present claim ? No  Yes

If yes, please explain : \_\_\_\_\_

2.8 Temporary assignment period : from \_\_\_\_\_ to \_\_\_\_\_

2.9 Date on which insured resumed regular work : \_\_\_\_\_

### 3. EMPLOYER'S SIGNATURE

Administrator's signature : \_\_\_\_\_ Date : \_\_\_\_\_