Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com/send
All provinces or territories – except Quebec: 1-800-278-0669
Quebec: 1-888-558-5525

Individual Insurance

Disability Claim

Disabled Person's Statement

We are unable to assess this claim unless all questions are answered completely.

A. Identification

Contract number

Disabled person's last name	First name	Date of birth (YYYY-MM-DD)	
Address – No., street, apt.	City	Province	Postal code
10-digit phone number — Home	Work	Extension	
Training	Level of education		

B. General information

1. Date of first symptoms related to the current disability (YYYY-MM-DD)

2. Date of first visit to a physician for this illness or injury (YYYY-MM-DD)

3. Was this an accident? ☐ Yes ☐ No

If yes, date of accident (YYYY-MM-DD)

Time ☐ AM ☐ PM

Type of accident ☐ Work-related ☐ Motor vehicle ☐ Other

Describe the accident and the circumstances surrounding it.

4. What were your activities before the current disability?

Domestic	Sports	Social and cultural

5. a) Date on which you stopped working or performing your normal activities as a result of the illness or accident: (YYYY-MM-DD) :

b) Last full day of work (YYYY-MM-DD) :

6. Have you resumed your normal activities? ☐ Yes ☐ No If yes, since what date? (YYYY-MM-DD)

7. a) Have you returned to work? ☐ Yes ☐ No

If yes, since what date? (YYYY-MM-DD)

Was this return to work: ☐ gradual ☐ full-time ☐ part-time ☐ a temporary assignment

b) Is this a temporary assignment? ☐ Yes ☐ No If yes, since what date? (YYYY-MM-DD)

8. Are you currently a student? ☐ Yes ☐ No

If yes, since what date? (YYYY-MM-DD)

Number of class hours per week

9. Describe any treatments you're currently receiving (physiotherapy or other) and list any medications you're taking as a result of your disability. For each one, specify the number of times per day, per week or per month that you receive these treatments.

10. Describe how your disability prevents you from working:

11. Briefly describe your current daily activities since you stopped working:

Disabled person's last name	First name	Date of birth (YYYY-MM-DD)

B. General information (cont.)

12. Please provide the names and addresses of any physicians who have treated you for your disability:

13. Name of your personal physician: | Since what date? (YYYY-MM-DD)

14. Have you consulted a physician or a health care professional or have been hospitalized for one or more medical reasons over the 5 years preceding your current disability?
☐ Yes ☐ No If yes, complete the table:

Name of physicians or health care professionals who treated you	Type of illness or injury	Date of consultations (YYYY-MM-DD)	Name of hospitals where you were treated	Hospitalization periods (YYYY-MM-DD)
				From: To:
				From: To:

15. Prior this disability, have you taken any medication during the last 5 years? ☐ Yes ☐ No If yes, complete the table:

Illnesses	Name of medication	Periods (YYYY-MM-DD)

16. During the 2 years prior to the current disability, did you miss work due to an illness or accident? ☐ Yes ☐ No If yes, specify:

Date of absence (YYYY-MM-DD)		Reason
From:	To:	

17. a) Have you smoked cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes, such as nicotine gum, nicotine patches or e-cigarettes in the past twelve (12) months? ☐ Yes ☐ No

b) When did you start smoking? (YYYY-MM-DD) | c) When did you stop smoking? (YYYY-MM-DD)

d) Specify non-smoking periods

18. a) Have you filed a claim with a government agency or another company? ☐ Yes ☐ No

⚠ **If yes, attach the notice of approval or rejection.**

	Yes	No	Date filed (YYYY-MM-DD)	Was your application approved?	Monthly amount	Payment period (if limited)
Pension plan ☐ federal	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ provincial	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ private	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ Provincial automobile insurance plan	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ Provincial workers' compensation plan	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ Any other government plan	☐	☐		☐ Yes ☐ No ☐ Being processed		
Other insurance: ☐ individual	☐	☐		☐ Yes ☐ No ☐ Being processed		
☐ group	☐	☐		☐ Yes ☐ No ☐ Being processed		

If yes, please provide the names of the government agencies administering the plans or the insurance companies and the contract or reference numbers:

b) Do you have or will have other souces of income? ☐ Yes ☐ No Weekly amount:

☐ Holiday pay ☐ Maternity ☐ Sick leave ☐ Salary
☐ EI benefits ☐ Lump sum ☐ Desjardins Insurance (other contracts) ☐ Other:

19. Are you:

☐ a salaried worker ☐ a self-employed worker ☐ other (please specify: on maternity leave, retired, unemployed, etc.):

⚠ **If you're a salaried or self-employed worker, please answer the questions in section C. Employer or self-employed individual's statement below.**

Disabled person's last name	First name	Date of birth (YYYY-MM-DD)

C. Employer or self-employed individual's statement

1. Current weekly salary:	2. Hours worked/week
3. Date of employment (YYYY-MM-DD):	4. Occupation:

5. Are you still with your employer? ☐ Yes ☐ No If not, what was your date of departure? (YYYY-MM-DD)

Reason:

6. On average, how many hours per week did you work in the 4 weeks before your disability?

7. What are the main duties of the disabled person's job and how much time is allocated to each one weekly?

⚠ **Please attach a brief job description if available.**

Duties:	%	Duties:	%
Duties:	%	Duties:	%

8. Describe activity and specify frequency and weight:

⚠ **Frequency:**
Occasionally: 0-15% of the time **F**requently: 16-50% of the time **A**lways: 51% + of the time

	Frequency: O	F	A	Weight
☐ Pushing	☐	☐	☐	
☐ Pulling	☐	☐	☐	
☐ Lifting/carrying	☐	☐	☐	

Please list any office equipment, motor vehicle, tools or other equipment that is used in the disabled person's job.

Type of equipment	Times per day	Type of equipment	Times per day

9. Identification of employer

Name of employer	10-digit phone number	Ext.	10-digit fax number

Address – No., street, apt.	City	Province	Postal code

Name of contact	Title

Email address

D. Declaration

I declare that all the information given above is complete and true.

X _____ _____
Signature of disabled person Date (YYYY-MM-DD)

Disabled person's last name	First name	Date of birth (YYYY-MM-DD)

E. Reimbursement agreement

If I am entitled to disability payments from another insurance company or government agency, I agree to reimburse Desjardins Insurance for any overpayment made to me. I will reimburse Desjardins Insurance as soon as I receive a payment from another insurance company or government agency. In the event of bankruptcy, I agree to notify Desjardins Insurance immediately. A photocopy of this agreement is as valid as the original. I agree to inform Desjardins Insurance if I receive benefits from any other source.

X _____ _____
Signature of disabled person — Date (YYYY-MM-DD)

F. Authorization to collect and communicate personal information

Disabled person's last name and first name	Contract number	Date of birth (YYYY-MM-DD)

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers:

- to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, LLC, insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers;
- to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file;
- to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed;
- to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file;
- to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits;
- to provide a brief report on my personal information, including my health information, to MIB, LLC.

This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

X _____ _____
Signature of disabled person — Date (YYYY-MM-DD)

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