

# Claimant's Guide

## Disability Insurance



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## FORMS TO COMPLETE

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- Authorization Forms
- Request for Payment by Direct Deposit
- Employer’s or Self-employed Worker’s Statement
- Attending Physician’s Statement

### 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](mailto:claimslife.disability@ont.bluecross.ca)

**Québec Office**

1981 McGill College Avenue, Suite 105

Montreal, Quebec H3A 0H6

**Email:** [claimslife.disability@qc.bluecross.ca](mailto: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 ?**

You 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.



# 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 INFORMATION**

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 <b>before</b> disability (in minutes)	Ability <b>since</b> disability (in minutes)	Did you change how you carry out this activity?
Walk			<input type="checkbox"/> yes <input type="checkbox"/> no
Run			<input type="checkbox"/> yes <input type="checkbox"/> no
Remain standing			<input type="checkbox"/> yes <input type="checkbox"/> no
Remain seated			<input type="checkbox"/> yes <input type="checkbox"/> no
Climb up stairs			<input type="checkbox"/> yes <input type="checkbox"/> no
Climb down stairs			<input type="checkbox"/> yes <input type="checkbox"/> 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 Revenue 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.

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



**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	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Wash dishes	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Drive a vehicle	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Take the bus	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Sweep	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Use the vacuum cleaner	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Do the laundry	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Take out the garbage	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Make the bed	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Shovel snow	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Cut the grass	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Do the grocery shopping	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Shop	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Outings (cinema, concerts, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Watch television	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Read (newspaper, magazine, book)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Play games (cards, checkers, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Manage the budget	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

OTHER INFORMATION	
1. Are you licensed to drive a vehicle?	<input type="checkbox"/> yes <input type="checkbox"/> no      If yes, indicate permit class: _____
2. Has your licence been suspended?	<input type="checkbox"/> yes <input type="checkbox"/> no      If yes, for how long: _____
3. For what reason? _____ _____	

DECLARATION
<b>I hereby certify that the above information is, to the best of my knowledge, true and complete.</b>
Signature of claimant: _____ Date: _____ day / month / year



# 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 MIB, Inc. 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 and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada, hereafter called 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.

\_\_\_\_\_  
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



# 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 MIB, Inc. 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 and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada, hereafter called 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.

\_\_\_\_\_  
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



# 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 MIB, Inc. 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 and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada, hereafter called 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.

\_\_\_\_\_  
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



# Request for Payment by Direct Deposit

## IDENTIFICATION

Name of claimant: \_\_\_\_\_ Policy No: \_\_\_\_\_

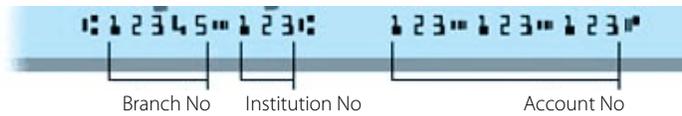
## BANK ACCOUNT DETAILS

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.



## 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**



<b>WORKING ENVIRONMENT INFORMATION</b> – 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) _____							

<b>PHYSICAL EFFORT INFORMATION</b> – To what extent must this employee do as follows? (check as applicable):							
	Rarely	Not often	Often	Very often	Constantly	Never	n/a
<b>Position</b>							
Sit							
Stand							
Walk							
Crouch on knees							
Crawl							
Stretch arms above shoulder height							
Stretch arms below shoulder height							
Climb up and down stairs							
<b>Effort</b>							
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

<b>PSYCHOLOGICAL EFFORT DETAILS</b> – 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							

<b>STATEMENT</b>	
<b>I hereby certify that the information provided hereinabove is, to the best of my knowledge, true and complete.</b>	
Name of company: _____	
Address: _____	
Telephone: (_____) _____ Fax: (_____) _____ E-mail: _____	
Name of signatory: _____ Title: _____	
Signature: _____ Date: _____ day / month / year	



# 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**



<b>WORKING ENVIRONMENT INFORMATION</b> – 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) _____							

<b>PHYSICAL EFFORT INFORMATION</b> – To what extent must you do as follows? (check as applicable):							
	Rarely	Not often	Often	Very often	Constantly	Never	n/a
<b>Position</b>							
Sit							
Stand							
Walk							
Crouch on knees							
Crawl							
Stretch arms above shoulder height							
Stretch arms below shoulder height							
Climb up and down stairs							
<b>Effort</b>							
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

<b>PSYCHOLOGICAL EFFORT INFORMATION</b> – 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

## Attending Physician's Statement - Short Term Disability Claim

### Plan Member/Employee Information and Consent: To Be Completed By The Patient

Plan Member/Employee Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name		Plan Contract #	Member Certificate #
Height	Weight	Date of Birth (dd/mm/yyyy) _____	
Last Date Worked (dd/mm/yyyy) _____		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____	
<p>I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. <b>Medical and health information excludes genetic test results.</b></p>			
Plan Member/Employee Signature		Date of Consent (dd/mm/yyyy)	

### Questions To Be Completed By the Physician (or Nurse Practitioner Where Applicable)



- If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete **Page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete **Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Secondary and/or Complications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): \_\_\_\_\_ Vaginal  C-Section

Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto accident Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date of event: (dd/mm/yyyy) _____	If yes, date of event: (dd/mm/yyyy) _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) \_\_\_\_\_ First date of work absence due to condition: (dd/mm/yyyy) \_\_\_\_\_

**Hospitalization** Is/was patient hospitalized  or had day surgery  Please provide the following information or attach a copy of the discharge report:  
 Date of admittance (dd/mm/yyyy) \_\_\_\_\_ Date of discharge (dd/mm/yyyy) \_\_\_\_\_ Institution Name \_\_\_\_\_  
 \_\_\_\_\_

If surgery was performed related to this work absence, please provide date and description of surgery  
 Date (dd/mm/yyyy) \_\_\_\_\_ Description: \_\_\_\_\_

**Treatment** (drug, dosage, physiotherapy, other):  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prognosis** Please provide the prognosis for recovery:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks**

Has the patient been treated for this same or similar condition in the past? Yes  No

If yes, date: (dd/mm/yyyy) \_\_\_\_\_ Treatment Provider: \_\_\_\_\_

Please describe the patient's symptoms including history, severity and frequency: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Frequency of Visits:  Weekly  Monthly  Other \_\_\_\_\_



**Please attach copies of all relevant:**

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - **do not provide genetic test results.**
- consultation reports • clinical notes

**If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.**

Name of Specialist \_\_\_\_\_ Specialty \_\_\_\_\_ Date of Visit \_\_\_\_\_

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the patient following the recommended treatment program? Yes  No

Do you have concerns about the patient's ability to manage his/her own affairs? Yes  No

**Prognosis** Please provide the prognosis for recovery: (if not completed on page 1)

\_\_\_\_\_  
 \_\_\_\_\_

**Notice to Physician**

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code)
		Fax # (+ area code)

Signature or Stamp \_\_\_\_\_



## Attending Physician's Questionnaire – Mental Health Conditions

<b>Section A</b>	<b>Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT</b>		
Plan Member/Employee Name (Last, First, Middle Initial)		Phone # (+ Area Code)	E-mail address
Address (Street, City, Province, Postal Code)			
Employer's Name		Plan Contract #	Member Certificate #
Date of Birth (dd/mm/yyyy)			
Date Last Worked (dd/mm/yyyy)	Date Returned to Work or Expected Return to Work Date, if known (dd/mm/yyyy)	Please provide your: Height: _____ Weight: _____	
<p>I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. <b>Medical and health information excludes genetic test results.</b></p>			
Plan Member/Employee Signature		Date of Consent (dd/mm/yyyy)	
<b>Section B</b>	<b>Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR</b>		
I am the:    Attending Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____			
<b>PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE</b>			
<b>1) Diagnosis</b>			
Primary: _____			
Secondary: _____			
Is this condition related to: <input type="checkbox"/> Occupational Illness/injury <input type="checkbox"/> Auto accident    If so, date of event: (dd/mm/yyyy) _____			
Details: _____			
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____		First date of work absence due to this condition: (dd/mm/yyyy) _____	
Has the patient been treated for this same or similar condition in the past?    Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, date: (dd/mm/yyyy) _____ By whom: _____			
Have you completed any other disability claim forms recently for this patient?    Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____			

**2) Patient's Description of Symptoms**

Please describe the patient's current symptoms including frequency and severity:

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**3) Your Clinical Findings and Observations**

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy / Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration / Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect/Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight/Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Observations or comments supporting the above:

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**4) Complicating Factors**

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

- Workplace Issues       Social / Family Issues       Financial / Legal Problems
- Physical Condition       Alcohol / Drug Abuse       Medication Side Effects
- Pain Perception       Coping Skills       Personality / Motivation       Other

Please describe:

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Please describe the supports in place, or planned, to assist with these issues:

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**5) Investigations**

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - **do not provide genetic test results.**
- consultation reports

Are tests / investigations / consultations pending? Yes  No  Date report expected: (dd/mm/yyyy) \_\_\_\_\_

Does the patient have an appointment booked with any specialist(s) in the near future? Yes  No

Name of Specialist	Specialty	Date of Appt: (dd/mm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Reason for requesting the consultation:

\_\_\_\_\_

\_\_\_\_\_

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes  No  Don't Know

If yes, as of when? (dd/mm/yyyy) \_\_\_\_\_ Type of licence: \_\_\_\_\_

**6) Medications** (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

**7) Hospitalization**

Is/was the patient hospitalized? Yes  No  Is future hospitalization anticipated? Yes  No

Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)	Institution Name
1. _____	_____	_____
2. _____	_____	_____

**8) Treatment Details - Psychological** (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

**9) Treatment Details - Concurrent Physiological Disorders, if known** (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

**10) Overall Response to Treatment**

Please describe the response to treatment to date: Complete  Partial  None  Too soon to tell

Is the patient following the recommended treatment program? Yes  No   
Please explain: \_\_\_\_\_  
\_\_\_\_\_

Are there any plans to change or augment the current treatment program? Yes  No   
If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

**11) Prognosis and Recovery**

What return-to-work goals have been discussed with the patient? Please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the patient's prognosis for improvement: \_\_\_\_\_

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Notice to Physician**  
The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code)
		Fax # (+ area code)
Signature or Stamp		



# Notes



# 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](mailto:claimslife.disability@ont.bluecross.ca)

**Québec Office**

1981 McGill College Avenue, Suite 105

Montreal, Quebec H3A 0H6

**Email:** [claimslife.disability@qc.bluecross.ca](mailto:claimslife.disability@qc.bluecross.ca)



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