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/Terr. | 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:<br>To: |
| | | | | From:<br>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<br>☐ 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:<br>☐ 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:**
**O**ccasionally: 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/Terr. | Postal code |
|---|---|---|---|
| | | | |

| Name of contact | Title |
|---|---|
| | |

Email address

## D. Consent related to the management of your personal information by Desjardins Group

**1. Management of your personal information**

To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy.

You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy.

Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.

**2. Your rights**

You can:

- See the personal information Desjardins Group has about you
- Correct any information that's incomplete, ambiguous or not relevant

To find out how, see Desjardins Group's Privacy Policy.

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

**3. Collection or transfer of your personal information outside of Canada**

Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country.

For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us a 1-800-463-7870.

**By signing this form, you:**

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at www.desjardins.com/privacy-policy
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

⚠ Please sign the last page of this form

## E. Consent related to the information Desjardins Insurance gets about you

**1. Why Desjardins Insurance needs your consent**

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance
- Ask a personal information broker to provide us with an investigation report about you, if necessary
- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.
- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted

By giving your consent to us, you also authorize our reinsurers to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

**2. Who your personal information will be collected from or disclosed to**

You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include:

- MIB, LLC
- Healthcare professionals or establishments (doctors, hospitals, clinics, etc.)
- Healthcare providers
- Paramedical firms
- Public or parapublic organizations
- Insurance companies other than Desjardins Insurance
- Reinsurers
- Your employer or a former employer
- The policyowner (also called policyholder or contract holder), if you aren't that person
- Other Desjardins components, if they're involved in the insurance
- A personal information broker or an investigation firm

**By signing this form, you:**

- Authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy.

⚠ Please sign the next page of this form

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

## F. Declarations

- I declare that the information you have provided here is complete and accurate.
- 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.

## G. Signatures

x _____ _____

Signature of the disabled person

Date (AAAA-MM-JJ)