INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Public Service Management Insurance Plan

Claim for Long Term Disability Benefit

Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

A CLAIM CONSISTS OF FORM 5945 (PARTS 1 AND 2) AND FORM 5946 (PARTS 1, 2 AND 3).

Instructions to Claimant (Form 5945 – attached)

Please complete and sign Part 1 of the attached form. Also complete and sign the authorization at the beginning of Part 2. Then forward the form to the attending physician. Once the entire form has been completed it should be sent directly to Industrial Alliance at the address below, at least two months prior to the date you expect your benefits to become payable, if the claim is approved.

Group Disability Claims
Industrial Alliance Insurance and Financial Services Inc.
522 University Avenue
Toronto, Ontario M5G 1Y7

You are responsible for any costs associated with the completion of the form.

Answer all questions fully. If there is insufficient space for your answers, use separate sheets and attach them to the form.

Please note: Form 5946 must also be completed.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.

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AVIS :
Cette formule est disponible en français

PART 1: MEDICAL INFORMATION. TO BE COMPLETED BY THE MEMBER. **ATTACH TO PART 2**

Your full name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Date of birth Y M D
Social Insurance Number (required for income tax purposes)	Individual Agency No. (IAN)
Address	
Postal Code	Telephone ( )

Present illness, injury or disabling condition

Nature of condition	Date first symptoms of your condition appeared Y M D	Date first consulted a physician for your condition Y M D
Name of physician. If more than one physician consulted, please list.	Address of physician(s)	
Date of hospitalization (if any). If more than one period of hospitalization, please list. From Y M D to Y M D	Hospital name(s) and town(s)	

Recent illnesses, injuries or disabling conditions (within the last 5 years)

Nature of condition	Period condition lasted From Y M D to Y M D
Name of physician. If more than one physician consulted, please list.	Address of physician(s)
Treatment(s) prescribed (medicines, diets, etc.)	
Date of hospitalization (if any). If more than one period of hospitalization, please list. From Y M D to Y M D	Hospital name(s) and town(s)
Surgical procedures performed	

Nature of condition	Period condition lasted From Y M D to Y M D
Name of physician. If more than one physician consulted, please list.	Address of physician(s)
Treatment(s) prescribed (medicines, diets, etc.)	
Date of hospitalization (if any). If more than one period of hospitalization, please list. From Y M D to Y M D	Hospital name(s) and town(s)
Surgical procedures performed	

PART 1: (continued)

Nature of condition	Period condition lasted From Y M D to Y M D
Name of physician. If more than one physician consulted, please list.	Address of physician(s)
Treatment(s) prescribed (medicines, diets, etc.)	
Date of hospitalization (if any). If more than one period of hospitalization, please list. From Y M D to Y M D	Hospital name(s) and town(s)
Surgical procedures performed	

I certify that the above is true and complete and I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, my employer or other organization, institution or person that has any records or knowledge of me or my health to give to Industrial Alliance Insurance and Financial Services Inc. any such information. I also authorize Industrial Alliance Insurance and Financial Services Inc. to release such documentation or information to any Independent Medical Examiner when Industrial Alliance Insurance and Financial Services Inc. deems it necessary for the purpose of adjudicating or administering this claim. In addition, I consent to a personal investigation. A photostatic or carbon copy of this authorization shall be as valid as the original.

Date signed	Member's signature

PART 2: MEDICAL INFORMATION. ATTENDING PHYSICIAN'S LONG TERM DISABILITY BENEFITS STATEMENT

Patient's name	Age
I hereby authorize the release to Industrial Alliance Insurance and Financial Services Inc. of any information requested in respect of this claim.	
Date	Signature of Patient

The patient is responsible for the securing of this form and any charge which may be made for its completion.
ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY. TO PHYSICIANS – PLEASE NOTE:

This form has been specifically designed with the Physician in mind. By being comprehensive, it will hopefully reduce the Physician's administrative workload. Please complete the sections relating to your patient and stroke out non-applicable areas. In order to help the claimant, sufficient details of History, Investigation, Findings and Treatment are essential.

This form may be mailed directly to Industrial Alliance Insurance and Financial Services Inc. or given to the patient at the Physician's discretion. If mailed direct, please address to: Group Disability Claims Department, Industrial Alliance Insurance and Financial Services Inc., 522 University Avenue, Toronto, Ontario M5G 1Y7. Part 1 completed by the patient should be attached.

1. History

(a) When did symptoms first appear or accident happen? Y M D	(b) Date total disability commenced? Y M D
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown If "Yes", state when and describe.	(d) Is condition due to a physical or mental impairment arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
(e) Names of other treating physicians	

2. Diagnosis

(a) Diagnosis (including any complications) Primary _____ Secondary (if applicable) _____
(b) Subjective symptoms
(c) Objective findings (including results of current x-rays, E.K.G.'s or any other special tests)

3. Treatment

(a) Date of first visit Y M D	(b) Date of latest visit Y M D
(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)_____	(d) Is patient following recommended treatment program? ☐ Yes ☐ No

4. Type of Treatment

(a) Describe therapy and projected duration of treatment program.
(b) Date and description of surgery (if applicable) Y M D

5. Physical Impairment

Is patient:
☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined?

If ambulatory and/or house confined, please complete the section below:

☐ No limitation of functional capacity, capable of strenuous activity
☐ Minimal limitation of functional capacity; capable of moderate activity
☐ Medium limitation of functional capacity; capable of light activity
☐ Severe limitation of functional capacity; incapable of minimal activity

Remarks:

_____

_____

6. Mental Impairment

- ☐ No limitation of functional capacity; capable of functioning under stress and engaging in interpersonal relations
- ☐ Minimal limitation of functional capacity; capable of functioning in most stress situations and engaging in most interpersonal relations
- ☐ Moderate limitation of functional capacity; capable of functioning in only limited situations and engaging in only limited interpersonal relations
- ☐ Marked limitation of functional capacity; incapable of functioning in stress situations or engaging in interpersonal relations
- ☐ Severe limitation of functional capacity; significant loss of psychological, physiological, personal and social adjustment

Remarks

_____

7. Effect of Physical or Mental Impairment on Duties of Job

Please explain the extent to which the patient's physical or mental impairment affects his or her capacity to:

(a) perform his or her regular duties

(b) perform any other occupation compatible with the patient's condition

(c) if physical impairment involved, what are the effects on:

(i) Patient's regular Occupation _____

(ii) Any other Occupation _____

8. Prognosis

	Regular Occupation	Any other Occupation
(a) Does disability prevent patient from performing?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If "Yes", please indicate when you do expect patient will recover sufficiently to perform duties of	☐ 1 - 3 months ☐ 3 - 6 months ☐ Other _____ ☐ Never	☐ 1 - 3 months ☐ 3 - 6 months ☐ Other _____ ☐ Never
(c) If "No", please indicate date patient was able to perform duties of	Y M D	Y M D

9. Cardiac (if applicable)

(a) Functional capacity ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood Pressure (latest visit) _____ Systolic/Diastolic

10. Visual Impairment (if applicable)

		O.D.	O.S.
(a) What was vision at latest observation	(i) With glasses	_____	_____
	(ii) Without glasses	_____	_____

(b) Vision can be restored in whole or in part by

☐ O.D.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable
☐ O.S.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable

11. Rehabilitation

	For regular Occupation	For any other Occupation
(a) Is patient a suitable candidate for trial employment?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If "Yes", when could trial employment commence? ☐ Full-time	Y M D	Y M D
☐ Part-time	Y M D	Y M D

(c) Would vocational counselling and/or retraining be recommended? ☐ Yes ☐ No

Remarks

_____

Physician's name (please print)

Address

Postal Code	Telephone
	( )

Date	Certified Specialist	Signature
	☐ Yes ☐ No	M.D.

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INSURANCE AND FINANCIAL SERVICES INC.

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Claim for Long Term Disability Benefit

Industrial Alliance Insurance and Financial Services Inc.

Group Policy No. G68-1400

A CLAIM CONSISTS OF FORM 5946 (PARTS 1, 2 AND 3) AND FORM 5945 (PARTS 1 AND 2).

Instructions to Claimant (Form 5946 – attached)

Please complete and sign Part 1 of the attached form. Then forward the form to your personnel officer at least two months prior to the date you expect your benefits to become payable, if the claim is approved.

Answer all questions fully. If there is insufficient space for your answers, use separate sheets and attach them to the form.

Please note: Form 5945 must also be completed.

Instructions to Personnel Officer (Form 5946 – attached)

Please review Part 1 of the attached form to make certain that it has been fully completed. Please complete and sign Part 2. Then forward the form to Superannuation Directorate, Public Works and Government Services Canada.

The information you provide in the attached form is collected under the authority of the Treasury Board for the administration of the Public Service Management Insurance Plan. All information provided is strictly confidential.

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FOR DEPT. USE

Name of Department or Agency	Location	Individual Agency No. (IAN)	Superannuation No.

PART 1: TO BE COMPLETED BY THE MEMBER (CLAIMANT)

Name of Member
☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Date of birth
Y M D

Address

Postal Code

Telephone
( )

Have you applied for any of the following benefits?

		Yes	No
(a)	Canada Pension Plan/Quebec Pension Plan	☐	☐
(b)	Public Service Superannuation Act	☐	☐
(c)	Other group insurance (including that available through your membership in an Association)	☐	☐
(d)	Workers' Compensation Legislation	☐	☐
(e)	Other government plans	☐	☐
(f)	Auto Insurance	☐	☐

If "Yes" to any of the above, please give details in "Remarks" below – sources, amount, commencement date.
If "No" to any of the above, please give reasons for not applying.

Remarks

First day on which you could not work due to this disability
Y M D

Please note that the LTD benefit is subject to income tax. For Quebec residents, it is required that Quebec Income Tax be deducted at source. For Federal Income Tax, deduction at source is not necessary, but can be arranged if desired.

Personal exemptions $ _____ (Quebec only)

For Federal Income Tax, please ☐ do not withhold

☐ withhold $ _____ per month or _____ %.

Remarks

PART 1: (continued)

Name of your immediate Supervisor

Address of your place of employment

Your job title (not code)

Details of job responsibilities

Educational background and work history, or attach your most recent curriculum vitae.

How your condition affected your work

Have you returned to work, or do you expect to?

I certify that the above is true and complete and I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, my employer or other organization, institution or person that has any records or knowledge of me or my health to give to Industrial Alliance Insurance and Financial Services Inc. any such information. I also authorize Industrial Alliance Insurance and Financial Services Inc. to release such documentation or information to any Independent Medical Examiner when Industrial Alliance Insurance and Financial Services Inc. deems it necessary for the purpose of adjudicating or administering this claim. In addition, I consent to a personal investigation. A photostatic or carbon copy of this authorization shall be as valid as the original.

Date signed	Member's signature

PART 2: TO BE COMPLETED BY THE PERSONNEL OFFICER

Member's name	Department Alpha Code	Pay office no.

BUD	Employee classification no.	IAN	According to proof on file, date of birth is Y M D

Last date of entry into public service Y M D	Effective date of LTD coverage Y M D	Authorized rate of pay and allowance for insurance $	Adjusted annual rate $

Date of last LTD deduction taken Y M D	Amount of last LTD deduction taken $

Status	FT	PT
Indeterminate		
Term more than 6 months		
Term less than 6 months		
Other		

For part-time Member:
Assigned hours/week _____

Effective date of above assigned hours
Y M D

Standard full-time hours/week _____

Date Member last actively at work prior to disability
Y M D

Reason for discontinued work (if other than disability)
_____

Date Member returned to work, if applicable Y M D	Anticipated date of return to work, if known Y M D

Date Member struck off strength, if applicable Y M D	Anticipated date Member will be struck off strength, if known Y M D

Total sick leave to Member's credit at date disability commenced	Date sick leave credits will be exhausted Y M D

Last day of qualifying period for disability benefits (13 weeks after disability commenced or date sick leave credits will be exhausted – whichever is later)
Y M D

Please attach a detailed job description and forward to Superannuation Directorate of Public Works and Government Services Canada.

Name of designated officer	Title

Location and complete address

Postal Code	Telephone ( )

Date	Signature of designated officer

PART 3: TO BE COMPLETED BY THE MEMBER'S SUPERVISOR

In what way was the Member's performance on the job affected by his/her disability?

_____

_____

_____

_____

Were the Member's duties modified? e.g.: Shorter hours, other jobs, etc.

_____

_____

Name of supervisor	Title

Location and complete address

Postal Code	Telephone ( )

Date	Signature of Supervisor

PART 4: TO BE COMPLETED BY THE SUPERANNUATION DIRECTORATE

LTD coverage is ☐ compulsory ☐ optional (copy of application attached)		
Member was senior executive ☐ Yes ☐ No	Monthly PSSA entitlement $	Effective date Y M D

Other coverages

Basic Life Insurance $	Supplementary Life Insurance $	A.D. & D. units
Dependent Life Insurance: ☐ Spouse and children ☐ Children only ☐ No coverage		
We certify that Long Term Disability Insurance was in force on the last day of active employment. We have confirmed that the adjusted annual rate shown by the personnel officer is correct.		
Date signed	Authorized signature	

Superannuation Directorate, please forward this form with job description to Industrial Alliance Insurance and Financial Services Inc..