



# REQUEST FOR DISABILITY BENEFITS

## GROUP INSURANCE

**IMPORTANT :** AS SOON AS AN EMPLOYEE IS ABSENT FROM WORK AND IS ELIGIBLE FOR DISABILITY BENEFITS, OR QUALIFIES FOR WAIVER OF PREMIUM, PLEASE TRANSMIT THIS FORM TO THE INSURER IMMEDIATELY. ANY INITIAL REQUEST SHOULD INCLUDE AN EMPLOYER'S DECLARATION, EMPLOYEE'S DECLARATION AND ATTENDING PHYSICIAN'S STATEMENT DULY COMPLETED AND SIGNED.

### EMPLOYEE'S DECLARATION

GROUP	DIVISION	CLASS	CERTIFICATE
NAME OF EMPLOYEE	SURNAME	DATE OF BIRTH D M Y	
ADDRESS			
CITY	PROVINCE	POSTAL CODE	
TELEPHONE NUMBER AREA CODE	NATURE OF DISABILITY		

WHEN WERE YOU UNABLE TO WORK DUE TO YOUR DISABILITY? D M Y

DATE YOU CONSULTED A DOCTOR FOR THE FIRST TIME AFTER YOU HAVE STOPPED WORKING D M Y

NAME OF PHYSICIAN \_\_\_\_\_

WHEN DO YOU EXPECT TO RETURN TO WORK? D M Y

WERE YOU HOSPITALISED? YES  NO  IF YES, DURING WHAT PERIOD : FROM \_\_\_\_\_ TO \_\_\_\_\_

NAME OF HOSPITAL \_\_\_\_\_

IS YOUR DISABILITY CAUSED BY AN ACCIDENT? YES  NO

IF YES, WHEN DID THE ACCIDENT TAKE PLACE? D M Y HOUR \_\_\_\_\_ A.M.  P.M.

WHERE DID THE ACCIDENT TAKE PLACE? \_\_\_\_\_

DESCRIBE THE CIRCUMSTANCES OF THE ACCIDENT : \_\_\_\_\_

DO YOU RECEIVE ANY OTHER DISABILITY BENEFITS? YES  NO

IF YES, FROM WHICH SOURCE? \_\_\_\_\_ SINCE WHAT DATE \_\_\_\_\_

HAVE YOU SUBMITTED A CLAIM TO ANY OTHER SERVICE SUCH AS :	CLAIM SUBMITTED	DATE	ACCEPTED - REFUSED	AWAITING RESPONSE
CANADA PENSION PLAN	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
QUEBEC PENSION PLAN	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
EMPLOYMENT INSURANCE AND IMMIGRATION CANADA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
WORKERS' COMPENSATION BOARD	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
SOCIÉTÉ DE L'ASSURANCE AUTOMOBILE DU QUÉBEC (S.A.A.Q.)	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
ANY OTHER ORGANISM OR INSURER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

PLEASE ATTACH TO THIS DOCUMENT A COPY OF DOCUMENTS RELATING TO THE CLAIM ACCEPTATION OR REFUSAL, WHATEVER THE CASE.

### AUTHORIZATION

I CERTIFY THAT THE FOREGOING INFORMATION IS ACCURATE AND COMPLETE AND AUTHORIZE ANY DOCTOR, HOSPITAL, CLINIC, INSURANCE COMPANY OR OTHER ORGANISM, INCLUDING WORKERS' COMPENSATION BOARD, S.A.A.Q. AND EMPLOYMENT INSURANCE AND IMMIGRATION CANADA OR ANY OTHER INSTITUTION OR PERSON IN CUSTODY OF A FILE OR PERSONAL INFORMATION OR ON MY HEALT CONDITION TO TRANSMIT TO **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)**, ANY INFORMATION ON MY HEALT CONDITION AND MY MEDICAL HISTORY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

<b>X</b>	<b>X</b>
DATE	SIGNATURE
NAME OF INSURED (PRINT)	