iA Financial Group

LONG-TERM DISABILITY CLAIM

GROUP INSURANCE

According to your region, please submit the completed form to:

Quebec
PO Box Station B
Montreal, Quebec H3B 3K6
Fax: 1-877-799-6691
Email: disabilitylife@ia.ca

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7
Fax: 1-877-781-1583
Email: disabilityclaims@ia.ca

PLEASE ANSWER ALL QUESTIONS. (PLEASE PRINT IN INK)

1. PLAN MEMBER INFORMATION

Last Name: ______________________ First name: ______________________

Claim no.: ______________ OR Policy no.: ______________ and certificate no.: ______________

Address: ____

____ Postal code: ______

Home Telephone: ______________ Cell Phone: ______________

2. INFORMATION ABOUT YOUR CURRENT CONDITION

Since our last update, has your condition: ☐ Improved ☐ Remained the same ☐ Deteriorated

Please describe: ____

____

Have you returned to school or taken any courses within the last 12 months? ☐ Yes ☐ No

If yes, please describe: ____

____

Have you participated in, or are currently participating in any volunteer activities? ☐ Yes ☐ No

If yes, please describe: ____

____

Have you returned to work? ☐ Yes ☐ No Date (Y M D) ______

Have you discussed returning to work with your attending physician? ☐ Yes ☐ No

If yes, please elaborate: ____

____

Please indicate whether you have applied for, or are receiving, any of the following benefits (complete section only if you have not done so previously):

Benefit	Applied	Date Applied	Approved	Date Benefit Began and Amount
Workers Compensation Benefits	☐ Yes ☐ No	DD-MM-YYYY	☐ Yes ☐ No	DD-MM-YYYY $__________
Canada Pension Plan (CPP) ☐ Disability or ☐ Retirement Quebec Pension Plan (QPP) ☐ Disability or ☐ Retirement	☐ Yes ☐ No	DD-MM-YYYY	☐ Yes ☐ No	DD-MM-YYYY $__________
Public Service Superannuation Act (PSSA) (for PSMIP members only)	☐ Yes ☐ No	DD-MM-YYYY	☐ Yes ☐ No	DD-MM-YYYY $__________
Disability benefits from auto insurer	☐ Yes ☐ No	DD-MM-YYYY	☐ Yes ☐ No	DD-MM-YYYY $__________
Other please describe:				

Please provide a copy of all correspondence regarding your benefit application, including the decision letter, if not already sent.

3. INFORMATION ABOUT YOUR CURRENT TREATMENT

Attending physician's name: ______________________________

Telephone number: | | | | | | | | | | | Date of last visit: Y | | | | M | | D | |

Current treatment plan: ______________________________

____

4. PLAN MEMBER CONFIRMATION/AUTHORIZATION

I CONFIRM that the statements provided in this form and all statements provided in any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge.

I AGREE that all such statements form the basis for the approval of continued benefits of this claim.

I HEREBY AUTHORIZE

(i) any healthcare provider or professional, medical organization, the MIB Inc., insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with iA Financial Group (Industrial Alliance Insurance and Financial Services Inc.), its employees, reinsurers or agency acting on behalf of iA Financial Group which is necessary for the purpose of assessing my disability claim;

(ii) iA Financial Group to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and

(iii) iA Financial Group and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

A photocopy of this Confirmation/Authorization shall be as valid as the original.
This Confirmation/Authorization is valid only for this disability claim.

Member's signature: ______________________________   Date Y | | | | M | | D | |

Address: ______________________________

______________________________   Postal code: | | | | | |

Home Telephone: | | | | | | | | | | | Cell Phone: | | | | | | | | | | |

iA Financial Group is a business name and trademark of
Industrial Alliance Insurance and Financial Services Inc.