HUMANIA ASSURANCE MD®

GROUP INSURANCE

DISABILITY CLAIM FORM

Initial assessment

HUMANIA ASSURANCE MD®

Group insurance
Disability claim form – Initial assessment

In order to ensure confidentiality of personal information, Humania Assurance will establish a claim file in which information concerning your claim will be recorded. Only employees or authorized agents of Humania Assurance responsible for the management of your claim shall have access to the file.

Instructions for:

A. The claimant

1. Please complete and sign the "Claimant statement" section.
2. Please ensure that the policyholder completes and signs the "Policyholder statement" section.
3. Please ensure that your physician completes and signs the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other condition or if you are insured under the Long Term Accident Disability coverage. As well, please provide your physician with a copy of your completed "Claimant statement" so that the physician has your signed authorization to release information to Humania Assurance.
4. Please note that any costs incurred for the completion of the "Attending physician statement" are your responsibility.
5. Please ensure that of the above-mentioned forms are submitted to Humania Assurance on a timely basis. Submitting them together will avoid unnecessary delays in the assessment of your claim. Also, please enclose a copy of the first and/or last unemployment statement and the record of employment form if applicable.
6. In cases of mental health issues, please make sure to contact your Employee Assistance Program today to get support as soon as possible. Call 1 800 668-0193 or visit login.lifeworks.com.

Direct deposit

7. Please complete and sign the direct deposit authorization form at the bottom of this page if you are not already using direct deposit with Humania Assurance. This form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

B. The policyholder

1. Please complete and sign the "Policyholder statement" section.
2. In order to avoid unnecessary delays in the processing of Long-Term Disability claims (without Short-Term Disability), we ask that these forms be completed and sent to Humania Assurance as follows and include a copy of the most recent Record of Employment (ROE):

   For policies with a waiting period of:

   - 17 weeks, completed forms should be sent to us as of the 9th week of absence;
   - 26 weeks, completed forms should be sent to us as of the 18th week of absence.

C. The physician

1. Please complete and sign the appropriate "Attending physician statement", depending on the nature of the primary diagnosis.

Direct deposit – Authorization

☐ Initial request for direct deposit ☐ Request for bank account change

I Insured statement (please print)

Policy and sub-group n°	Certificate n°	Surname	Given name(s)
Contact Number	Residence address (no., street)		Apt.
City	Province		Postal code
Financial institution name	Financial institution address		

II Type of bank account (please print)

☐ Chequing ☐ Savings

Branch n° (5 digit number)	Institution n° (3 – 4 digit number)	Account n°

III Authorization

I authorize Humania Assurance to use and disclose the bank account information in this authorization to Canada-wide financial institutions, using any electronic means, email, fax or mail, for the purpose of crediting benefit payments associated with this claim to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Humania Assurance of any subsequent changes.

I declare that I am aware of the rights granted by the Act respecting the protection of personal information in the private sector, including but not limited to the right to access information in the file that pertains to me, the right to have that information corrected, if need be, and the right to withdraw my authorization at any time.

Insured signature	Date (YYYY/MM/DD)
Account holder signature (if other than Insured)	Date (YYYY/MM/DD)

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Claimant statement

To be completed by the claimant. All questions must be answered in as much detail as possible.

Section A – General information

Gender ☐ Male ☐ Female ☐ Prefer not to respond	Date of birth (YYYY/MM/DD)	Policy n°	Certificate n°
Surname	Given name(s)	Email address	
Address (n°, street)			
City	Province	Postal code	Telephone n°	Language ☐ Fr. ☐ Ang.
Name of employer *(and division if different)*	Occupation *(prior to last day worked)*	Original date of hire (YYYY/MM/DD)	
Other current employer ☐ Yes ☐ No If yes, please name.			
Nature of request for benefits ☐ Short-Term Disability ☐ Waiver of premiums ☐ Long-Term Disability ☐ Compassion			

Section B – Claim information

Was the reason you stopped working due to
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident (not while working) ☐ Occupational illness or work accident
If you have suffered an injury, please describe how when, and where the injury occured.

Last day worked (YYYY/MM/DD)

Were you performing ☐ Your regular duties ☐ Modified duties | Was this a full day? ☐ Yes ☐ No

If not, how many hours did you work on your last day?

Date you were first unable to work (YYYY/MM/DD) | When did you first notice these symptoms? (YYYY/MM/DD)

When were you first treated by a physician for this condition? (YYYY/MM/DD)

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? ☐ Yes ☐ No If yes, please provide the dates and name(s) of physicians who treated you at the time.

Please describe the major duties of your occupation.

Please describe why you are unable to perform the duties of your occupation.

Please indicate if you are ☐ Right-handed ☐ Left-handed

Do you have an expected date of return to work? ☐ If yes, please provide the date (YYYY/MM/DD) ☐ No

Claimant statement (continued)

Section C – Health care professionals information

Please list all health care professionals that you have consulted **within the last 12 months,** starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name		Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)
Address (n°, street)		
Telephone n°	Fax n°	Specialty
Name		Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)
Address (n°, street)		
Telephone n°	Fax n°	Specialty
Name		Consulted from (JJ/MM/AAAA) to (JJ/MM/AAAA)
Address (n°, street)		
Telephone n°	Fax n°	Specialty

Section D – Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the appropriate section below and submit a copy of your notice of acceptance or refusal, if applicable.

Source	Claim n°, contact name, telephone n°	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Are you receiving payment? Pending	Monthly Amount
Worker's Comp – CNESST, WSIB, WCB		☐	☐	☐	☐	☐	
Crime victims compensation (IVAC)		☐	☐	☐	☐	☐	
Canada Pension Plan – Disability		☐	☐	☐	☐	☐	
Canada Pension Plan – Retirement		☐	☐	☐	☐	☐	
Quebec Pension Plan (QPP) – Disability		☐	☐	☐	☐	☐	
Quebec Pension Plan (QPP) – Retirement		☐	☐	☐	☐	☐	
Employment Insurance		☐	☐	☐	☐	☐	
Provincial auto insurance – SAAQ		☐	☐	☐	☐	☐	
Other insurer		☐	☐	☐	☐	☐	

Claimant statement (continued)

Section E – Claimant authorization and declaration

I authorize Humania Assurance, its agents, service providers and other partners (hereinafter «Business Partners») to collect, by any electronic means, email fax or mail and to use all personal information relevant to the adjudication of the claim submitted under this insurance policy as well as for statistical purposes.

I further authorize Humania Assurance to exchange the personal information collected about me with its Business Partners, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or other health professional any public or private health institution, any rehabilitation company, any pharmacist, any provincial health insurance plan, including but not limited to the Régie de l'assurance maladie du Québec, any insurer, any employer or any other person or institution in possession of medical or financial information about me. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

By providing my email address below, I authorize Humania Assurance to communicate with me by email concerning my present claim.

I declare that I am aware of the rights granted by the Act respecting the protection of personal information in the private sector; including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

Name (please print)	Signature
Policy n°	Date (YYYY/MM/DD)
Email Address	

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Policyholder statement

To be completed by the policyholder. All questions must be answered in as much detail as possible. *Please attach a copy of the most recent Record of Employment (ROE) as well as all medical information you may have since the beginning of the leave or absence.*

Section A – Policyholder information

Name of policyholder (Employer/Union/Association)	Name of subsidiary or division (if different)		
Address (n°, street)			
City	Province	Postal code	Telephone n°

Section B – Claimant information

Surname	Given name(s)		
Address (n°, street)			Birthday date (YYYY/MM/DD)
City	Province	Postal code	Telephone n°
Policy n°	Certificate n°	Permanent employee? ☐ Yes ☐ No	

Nature of request for benefits
☐ Short-Term Disability ☐ Long-Term Disability ☐ Waiver of premiums ☐ Compassion

Was the employee actively at work when the absence began/loss occured? ☐ Yes ☐ No
Please provide the date when this employee was first covered under this policy. (YYYY/MM/DD)

If no, please comment.

What was the employee's date of hire? (YYYY/MM/DD)	Last date of work? (YYYY/MM/DD)	Expected return to work date? (YYYY/MM/DD)

If the employee is already back at work, when was the start date? (YYYY/MM/DD)
☐ Part-time ☐ Full-time ☐ Temporary assignment ☐ Light duties ☐ Gradual – Please provide the return to work protocol

What was the claimant's main reason for the absence? ☐ Illness ☐ Injury away from work
☐ Motor vehicle accident (not while working) ☐ Occupational illness or work related accident ☐ Compassion

Please indicate the hours of work in a normal work week: _____h/week, from _____ to _____.
What is the employee's hourly rate? _____ $

Please indicate the employee's usual gross weekly earnings prior to disability. $_____ Last change date? ____(YYYY/MM/DD)____

Please indicate the employee's gross annual earnings for the current year. $_____ Last change date ? ____(YYYY/MM/DD)____

Was the employee ☐ Salaried ☐ Hourly ☐ On seasonal ☐ On call

Did the claimant receive any income during the disability period? ☐ Yes ☐ No
If yes, please select one of the following:
☐ Vacation ☐ Maternity leave ☐ Sick days
☐ Employment insurance ☐ Statutory holidays ☐ Other _____
☐ Employment Insurance caregiving benefits

Amount $ _____ From _____(YYYY/MM/DD)_____ to _____(YYYY/MM/DD)_____

Has the claimant submitted a claim to any of the following government agencies?
☐ WSIB/WCB/CNESST ☐ Employment insurance (Please enclose a copy of the record of employment form) ☐ CPP ☐ QPP (RQ)
☐ SAAQ – Provincial automobile insurance board ☐ Crime Victims Compensation Act

Policyholder statement (continued)

Section C – Occupational information

What was the claimant's regular occupation immediately prior to stopping work?

Were the claimant's duties modified from his/her regular occupation? ☐ Yes ☐ No

Please describe this employee's regular occupation (or attach a copy of the job description) as well as any modifications.

The following physical demands analysis of the claimant's occupation is to be completed by their supervisor. In the appropriate column, specify the amount of time spent on a regular basis on the following activities:

I) at any one time without a break (approximately) and;
II) in total throughout the day (approximately)

Physical demands analysis

		I	II
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down the stairs			
6. Lifting	0 – 10 pounds ☐ 10 – 20 pounds ☐ 20 – 50 pounds ☐ 50 pounds + ☐ with lifting device? Yes ☐ No ☐		
7. Pushing/Pulling	0 – 10 pounds ☐ 10 – 20 pounds ☐ 20 – 50 pounds ☐ 50 pounds + ☐		

Please describe work environment (i.e.: temperature, noise levels, chemical/dust exposure, etc.).

Does the claimant wear personal protective equipment (i.e.: safety glasses/footwear, respiratory protection, ear protection, etc.)? If yes, please describe.

Are there any circumstances or facts that would cause you to question the validity of the claim? ☐ Yes ☐ No If yes, please explain.

Email address for claim communications	Date (YYYY/MM/DD)
Name (please print)	Telephone n°
Signature of the authorized person	Job title

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Attending physician statement – physical conditions

In order for Humania Assurance to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form is the responsibility of the patient.

Section A – Information about the patient

Surname	Given name(s)	
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or the date that the accident occured? (YYYY/MM/DD)

What was the date of the patient's first visit for the current condition? (YYYY/MM/DD)

When was the patient's first visit with you regarding the present disability period? (YYYY/MM/DD)

When was the patient's first visit with a physician regarding the present disability period? (YYYY/MM/DD)

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, please provide dates and complete description.

According to the anamnesis and your clinical exam, is your patient's condition the result of an accidental event ☐ Yes ☐ No Please elaborate:

Is there a secondary diagnosis or additional complication which may affect the duration of the disability? ☐ Yes ☐ No
If yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should not** do)? Please be specific.

Is the patient's condition due to injury or sickness arising out of his/her employment? ☐ Yes ☐ No If yes, please elaborate.

Attending physician statement – physical conditions (continued)

Section B – Treatment - (suite)

If your patient ☐ Right-handed ☐ Left-handed

Is your patient competent to manage his/her own financial affairs? ☐ Yes ☐ No

If the patient was/is pregnant, please indicate the expected date of delivery. (YYYY/MM/DD)

Section C – Treatment

Frequency of patient visits ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Has the patient undergone or will he undergo:

Medical examens (X-ray, MRI or others) ☐ Yes ☐ No Please detail: _____

Surgery: ☐ Yes ☐ No ☐ Day surgery Type: _____ Date: (YYYY/MM/DD)

Other surgical intervention: _____

Other treatments: ☐ Yes ☐ No Please detail: _____

Hospitalization from (YYYY/MM/DD) to (YYYY/MM/DD) Name of hospital: _____

A short hospital stay for observation: ☐ Yes ☐ No Number of hours: _____

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Médication	Dosage	Date prescribed (YYYY/MM/DD)

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Section D – Prognosis

If a potential return to work date has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)

☐ Part-time ☐ Full-time ☐ Temporary assignment ☐ Light duties ☐ Gradual return to work – Please provide the return to work protocol

How long will the patient's leave of absence be?

☐ Less then 3 months ☐ From 3 to 6 month ☐ More then 6 month

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License n°
Address (n°, street)		
Telephone n°	Fax n°	

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Attending physician statement – psychological conditions

Does not apply for Long Term Accident Disability coverage

In order for Humania Assurance to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form is the responsibility of the patient.

Be sure to encourage your patient to contact their Employee Assistance Program (EAP) today so they can get additional support as soon as possible.

Section A – Information about the patient

Surname	Given name(s)	
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

Please indicate the patient's diagnosis:

Primary diagnosis:

Secondary diagnosis:

When did symptoms first appear? (YYYY/MM/DD)

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What was the date of the patient's first visit for their current condition? (YYYY/MM/DD)

What was the date of the patient's first visit during the present disability period? (YYYY/MM/DD)

Please describe the patient's initial reason for seeking treatment. Was there a precipitating event?

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

Is your patient's condition caused directly or indirectly by their employment? ☐ Yes ☐ No If yes, please elaborate.

Is your patient competent to manage their own financial affairs? ☐ Yes ☐ No

Attending physician statement – psychological conditions (continued)

Section C – Treatment

Frequency of patient visits ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Please detail the patient's past and present treatment (including psychotherapy), response to treatment, and compliance.

Type of therapy	Name of provider or facility	Date treatment began (yyyy/mm/dd)	Frequency of visits	Date of last visit (yyyy/mm/dd)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

Has the patient been hospitalized? ☐ Yes ☐ No If yes, please provide the name of the hospital(s) and the dates of admission.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

Section D – Evaluation

1. 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:

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

Attending physician statement – psychological conditions (continued)

Section D – Evaluation (continued)

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

None: no impairment in this area.
Mild: slight impairment that does not affect functional ability
Moderate: impairment affects but does not preclude ability to function.
Moderately severe: impairment significantly affects ability to function.
Severe: extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	☐	☐	☐	☐	☐
2. Ability to attend to personal care (bathing, cooking, etc.)	☐	☐	☐	☐	☐
3. Ability to carry out household chores	☐	☐	☐	☐	☐
4. Ability to relate to co-workers and supervisors	☐	☐	☐	☐	☐
5. Ability to perform work where contact with others will be minimal	☐	☐	☐	☐	☐
6. Ability to understand, carry out, and remember instructions	☐	☐	☐	☐	☐
7. Ability to perform tasks involving minimal intellectual effort or repetitive tasks	☐	☐	☐	☐	☐
8. Ability to perform a variety of tasks at the same time	☐	☐	☐	☐	☐
9. Ability to follow a regular work schedule	☐	☐	☐	☐	☐
10. Ability to make decisions	☐	☐	☐	☐	☐
11. Ability to perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	☐	☐	☐	☐	☐
12. Ability to supervise or manage others	☐	☐	☐	☐	☐

Section E – Prognosis

If a potential return to work date has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)

☐ Part-time ☐ Full-time ☐ Temporary assignment ☐ Light duties ☐ Gradual – Please provide the return to work protocol

How long will the patient's leave of absence be?

☐ Less then 3 months ☐ From 3 to 6 month ☐ More then 6 month

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License n°
Address (n°, street)		
Telephone n°	Fax n°	

Notes and Comments

To avoid any delay in the assessment of your claim, please complete and sign all the authorizations below, even if you completed the one found on page 3 of this document.

HUMANIA ASSURANCE MD®

Autorization

I authorize Humania Assurance, its agents, service providers and other partners (hereinafter "*Business Partners*") to collect, by any electronic means, email, fax or mail and to use all personal information relevant to the adjudication of the claim submitted under this insurance policy as well as for statistical purposes.

I further authorize Humania Assurance to exchange the personal information collected about me with its *Business Partners*, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or other health professional, any public or private health institution, any rehabilitation company, any pharmacist, any provincial health insurance plan, including but not limited to the Régie de l'assurance maladie du Québec, any insurer, any employer or any other person or institution in possession of medical or financial information about me. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

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I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector,* including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

Name (Please print)

Signature

Policy No.

Date (AAA/MM/JJ)

Email Address

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Autorization

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This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or other health professional, any public or private health institution, any rehabilitation company, any pharmacist, any provincial health insurance plan, including but not limited to the Régie de l'assurance maladie du Québec, any insurer, any employer or any other person or institution in possession of medical or financial information about me. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

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Name (Please print)

Signature

Policy No.

Date (AAA/MM/JJ)

Email Address

Humania Assurance Inc., 1555 Street Girouard West, Saint-Hyacinthe (Quebec) J2S 2Z6

4300-013 - Rev. 05/2023

HUMANIA ASSURANCE INC.

1555 Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6
Montreal region: 514 485-7236
Saint-Hyacinthe region: 450 773-7236
Other region: 1 800 818-7236
Web site: www.humania.ca

4300-058 Rev. 07/2023