HUMANIA ASSURANCE MD®

GROUP INSURANCE

COMPASSIONATE CARE LEAVE CLAIM FORM

Initial assessment

HUMANIA ASSURANCE MD®

Group Insurance
Compassionate care leave claim form

To ensure the confidentiality of personal information, Humania Insurance will establish a file that will contain all the documents related to your claims. Only authorized employees and representatives responsible for managing your claim will have access to this file.

Guidelines for:

A. The insured
1. Fill out and sign the section titled "Statement by the Insured."
2. Make sure the policyholder fills out and signs the section titled "Policyholder's Statement."
3. Make sure the doctor fills out the "Physician's Statement."
4. Please note that you must assume all costs for the attending physician's statement to be completed.
5. Submit all the forms mentioned above to Humania Assurance in a timely manner, being sure to send them all together to avoid any delay in assessing your claim. Please attach, if required, the stub from the first and/or last employment insurance cheque and your record of employment.

Direct deposit
6. If you are not already using Humania Assurance's direct deposit service, please fill out the authorization at the end of this page and submit it with your claim. Your benefits will be deposited directly to your bank account if your application is approved.

B. The policyholder
1. Fill out and sign the section titled "Policyholder's Statement."
2. Submit the claim forms in a timely manner. Duly completed forms must be sent to Humania Assurance as follows:
   Assurance de la façon suivante :
   - 15 weeks, the duly completed forms must be sent to us in the 8th week of absence;
   - 17 weeks, the duly completed forms must be sent to us in the 11th week of absence;
   - 26 weeks, the duly completed forms must be sent to us in the 20th week of absence...

C. The physician
1. Fill out the "Physician's Statement."

Direct deposit – Authorization

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

I. Declaration by the insured (please use block letters)

Policy and division no.	Certificate no.	Family name of the insured	Given name(s)
Telephone no. (day)	Address of the principal residence (number, street)		Apt.
City	Province		Postal code
Name of the financial institution	Address of the financial institution		

II Type of bank account (please write in block letters)

☐ Chequing ☐ Savings Please fill out this section or attach a specimen cheque so that we can obtain your banking information accurately.

Branch no. (5 digits)	Institution no. (3-4 digits)	Account no.

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 mentionned 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 neeed be, and the right to withdraw my authorization at any time.

Signature of the insured	Date (DD/MM/YYYY)
Signature of the account owner (if different from the insured)	Date (DD/MM/YYYY)

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For information, please contact us at: 1 877 987-3076 • Fax: 1 877 660-2519
Our address is: 1555 Girouard Strret West, Saint-Hyacinthe (Quebec) J2S 2Z6 • Email: claims@humania.ca • Web site: www.humania.ca

Statement by the Insured

Part 1 – Identification

Identity of the insured person

Policy no.	Division	Certificate
Family name	Given name(s)	
Social insurance number	Date of birth (YYYY/MM/DD)	
Address (number, street)		
City	Province	Postal code
Main telephone number	Other telephone number	

Identity of the family member for whom compassionate care leave is requested

Family name	Given name(s)	
Date of birth (YYYY/MM/DD)		
Address (number, street)		
City	Province	Postal code
Main telephone number	Other telephone number	

Is this:

- ❑ My spouse? Supporting evidence to be submitted: most recent federal tax report.
- ❑ My child? Supporting evidence to be submitted: birth or adoption certificate.
- ❑ My spouse's child? Supporting evidence to be submitted: most recent federal tax report and birth or adoption certificate.

If this is a child, is he or she: ❑ a full-time student ❑ a part-time student ❑ a non-student

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Statement by the insured

Part 2 – Certificate of work stoppage

Last day worked? (YYYY/MM/DD)

First day you did not work? (YYYY/MM/DD)

Since the last day of work, as noted above, has the family member for whom compassionate care leave is being requested engaged in work activities or studies?

❑ Yes, for the period from (YYYY/MM/DD) to (YYYY/MM/DD)

❑ No

Please outline why the health condition of your spouse or of the child requires that you stop working to take care of him or her?

Do you know the expected date of your return to work or resumption of your professional activities?

❑ Yes; if so, please indicate the date (YYYY/MM/DD) ❑ No

Part 3 – Information on income from other sources

If you are receiving income from one of the following sources, please fill out the corresponding part of the table and send us a copy of the notice of acceptance or rejection, as the case may be.

Source	Have you applied?		Have benefits been received?			Monthly amount
	Yes	No	Yes	No	Under study	
Employment Insurance (unemployment or illness)	❑	❑	❑	❑	❑	
Employment Insurance (compassion/caregiver)	❑	❑	❑	❑	❑	
Other insurer	❑	❑	❑	❑	❑	
Compensation from the CAT, CSAT or CNESST	❑	❑	❑	❑	❑	
Compensation for victims of crime (IVAC)	❑	❑	❑	❑	❑	
Canada Pension Plan disability benefits	❑	❑	❑	❑	❑	
Retraite Québec disability benefits	❑	❑	❑	❑	❑	
Automobile insurance – SAAQ	❑	❑	❑	❑	❑	

Part 4 – Declaration and authorization by the insured

As the insured under the present group insurance policy, I certify that the information provided in this compassionate leave claim is accurate and complete. At the same time, I certify that the family member identified in this claim requires my presence to take care of him or her.

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 ail 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 persona! 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 persona! 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 persona! 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	Signature
Policy no. - Division - Certificate	Email Address
Date (YYYY-MM-DD)	

Part 5 – Sick spouse or child over age 18

As the person identified in the present claim, 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 ail 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 persona! 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 persona! 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.

I declare that I am aware of the rights granted by the Act respecting the protection of persona! 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 of the insured | Policy - Division - Certificate

_____

Name of the spouse or sick child over age 18

_____ _____

Signature of the spouse or sick child over age 18 | Date (DD/MM/YYYY)

Part 6 – Sick child under age 18

As the person identified in the present claim, 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 ail 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 persona! 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 persona! 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.

I declare that I am aware of the rights granted by the Act respecting the protection of persona! 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 of the insured | Policy no. - Division - Certificate

_____

Name of the sick **child**

_____ _____

Signature of the **child** if age 14 or over in Québec or age 16 or over elsewhere in Canada | Date (DD/MM/YYYY)

_____

Name of the **parent** if the sick child is under age 18 in Québec or under age 16 elsewhere in Canada

_____ _____

Signature of the **parent** if the child is under age 18 in Québec or under age 16 elsewhere in Canada | Date (DD/MM/YYYY)

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Policyholder's statement for compassionate care leave

To be filled out by the employer. Answer all questions, providing as much detail as possible.

Part A – Information on the policyholder

Corporate name (name of the employer, union or association)	Corporate name of the subsidiary or division (if different)
Address (number, street)	

City	Province	Postal code	Telephone number
Email of contact person			

Part B – Information on the insured

Family name	Given name(s)

Policy no.	Division	Certificate	Telephone no.	Permanent employee? ☐ Yes ☐ No

Was the coverage in effect on the first day of the absence or the day of the event? ☐ Yes ☐ No
If yes, on what date did the claimant become insured under this policy? (DD/MM/YYYY)

If not, please specify.

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

If the claimant is already back at work, what was the date of return? (DD/MM/YYYY)
☐ Part-time ☐ Full-time ☐ Temporary assignment ☐ Light work ☐ Gradual – Please attach the return-to-work protocol

What was the main reason for the claimant's absence? ☐ Illness ☐ Injury outside of work
☐ Automobile accident outside of work ☐ Occupational illness or accident ☐ Compassion

Please indicate the work hours of a normal week.

Mon. _____ Tues._____ Wed._____ Thu._____Fri._____ Sat._____ Sun._____
(If the claimant works irregular hours or on shifts, please provide the corresponding schedule.)

What was the claimant's usual gross weekly salary prior to the absence? $_____ Date of the latest change _____(DD/MM/YYYY)

What is the claimant's gross annual salary for the current year? $ _____ Date of the latest change _____(DD/MM/YYYY)

Policyholder's statement (continued)

Part B – Information on the insured (continued)

The employee is ☐ Salaried ☐ Paid hourly ☐ On call

Did the claimant receive any income during the period of absence? ☐ Yes ☐ No
If yes, specify the source:
☐ Annual holiday ☐ Maternity leave ☐ Sick leave
☐ Employment Insurance (please attach a copy of the record of employment) ☐ Statutory holiday ☐ Other _____
☐ Employment Insurance for caregiver / compassion

Amount: $ _____ From _____ to _____

Has the claimant applied for benefits from the following government bodies?
☐ CSAT, CAT or CNESST ☐ Employment Insurance (attach a copy of the record of employment) ☐ CPP ☐ RRQ
☐ SAAQ or other provincial automobile insurance body ☐ IVAC

At the time of work stoppage, what was the employee's status? ☐ Working ☐ Temporary layoff ☐ Termination of employment
☐ Disabled ☐ Unpaid ☐ Other: specify _____

Do you have an agreement with the employee on the length of unpaid leave? ☐ Yes: length ☐ No _____

Are there circumstances leading you to question the validity of this claim? ☐ Yes ☐ No

If yes, please explain:

I certify that the information above is accurate and complete.	Date (DD/MM/YYYY)
Name (in block letters)	Telephone no.
Authorized signatory	Position

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Identity of the insured person		
Family name	Given name	
Policy no.	Division	Certificate

Physician's statement – To be completed for the spouse or the sick child

Part A – Information on the patient		
Name	Given name(s)	
Date of birth	Height	Weight

Part B – Diagnosis

What are the primary and secondary diagnoses of your patient?

What are the factors contributing to the above diagnoses?

In case of a cognitive impairment, please answer the following questions:
Is there mental deterioration and loss of intellectual ability shown through measurable deterioration of:

Memory: ☐ Yes ☐ No
Orientation: ☐ Yes ☐ No
Ability to reason: ☐ Yes ☐ No

Attach the specialist's report confirming this.

What is the demonstrable organic cause of this impairment?
Does the degree of cognitive impairment require daily supervision? ☐ Yes ☐ No Daily duration (hours per day) _____

What are the activities of daily living that your patient is no longer able to perform on his or her own?

	Total incapacity	Permanently?	Temporarily?	Specify the duration
Bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.	☐	☐	☐	
Dressing: the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.	☐	☐	☐	
Toileting: the ability to get on and off the toilet and maintain personal hygiene;	☐	☐	☐	
Bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained	☐	☐	☐	
Transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.	☐	☐	☐	
Feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.	☐	☐	☐	

In your professional opinion, does the patient require care or support from one or more family members? ☐ Yes ☐ No

If yes, please specify the number of hours per day:

Physician's statement

Part B – Diagnosis (continued)	
When did you examine the patient most recently?	(DD/MM/YYYY)
Has your patient been hospitalized now or previously?	❑ Yes ❑ No
Has your patient been treated as an outpatient?	❑ Yes ❑ No
If yes, please specify the name of the institution: And the period or expected duration:	
Describe the expected clinical course:	
Based on your latest examination on (DD/MM/YYYY), do you certify that the patient is seriously ill and seems likely to die in the next 12 months? ❑ Yes ❑ No	
Please indicate any other information that is relevant to understanding this case:	
In your professional opinion, and to the best of your knowledge, is the patient able to look after his or her own interests? ❑ Yes ❑ No	
Physician's signature	Date (DD/MM/YYYY)
Name (in block letters)	Specialty Permit no.
Address (number, street)	City / Province / Postal code
Telephone no.	Fax no.

HUMANIA ASSURANCE INC.

1555, rue Girouard Ouest, Saint-Hyacinthe (Québec) J2S 2Z6
Montréal area: 514 485-7236
Saint-Hyacinthe area: 450 773-7236
Other areas: 1 800 818-7236
Website: www.humania.ca

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