La Capitale
Financial Security
7150 Derrycrest Drive Mississauga ON L5W 0E5 www.lacapitaleFS.com

IMPORTANT!

1. DELAYS IN SUBMISSION COULD JEOPARDIZE YOUR ELIGIBILITY FOR BENEFITS. ENSURE YOUR FORM IS **FULLY** COMPLETED AND **SIGNED**.
2. ANY CHARGE FOR COMPLETING THIS FORM IS THE INSURED'S RESPONSIBILITY.
3. CALL US WITH ANY INQUIRIES TOLL-FREE 1 800 268-2835 OR LOCAL 905 795-2300.

POLICY Nº

YOUR HOME PHONE	**AREA CODE**
YOUR WORK PHONE	**AREA CODE**
YOUR CELL PHONE	**AREA CODE**

Part A Claimant's Preliminary Report

EMPLOYMENT INFORMATION

Insured's Name: _____

insured's occupation(s): _____

Self-Employed: Yes ____ No ____ (If yes, continue) If no, go to section **'Employees'**

Business Name: _____

Business Address: _____

Product/Service: _____

Date of most recent contract: _____ Type of Work: _____

Contact person of last contract: _____

Phone #: _____

Duration of last 3 contracts: _____

_____

Describe in detail your usual daily activities: _____

_____

_____

_____

Number of permanent employees: _____

Number of temporary or subcontractors: _____

List current contracts/work presently available: _____

If unemployed, confirm as of what date and provide proof: _____

INCOME

Average monthly income (includes salary, fees, bonus, wages or commissions, less allowable business expenses, before deduction of income tax):

_____

_____

Is your business still operating? _____

If so, what duties are you performing? _____

_____

EMPLOYEES

Employer: _____ Contact name/phone#: _____

Your title: _____

Describe your usual daily duties: _____

_____

_____

How many hours do you work per week? _____

What is your annual salary (includes salary, fees, bonus, wages or commissions, less allowable business expenses, before deduction of income tax)? _____

Is partial / light or modified work available? _____

ZSA-3455 (2022-11)

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INSURED'S PHONE	AREA CODE
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CONDITION TREATMENT

Names and addresses of current treating physicians: _____

_____

_____

_____

Name of regular family doctor and/or clinic: _____

Date and reason of last visit: _____

Why did you stop working? _____

Please indicate the date symptoms were first noticed: _____ Place: _____

Describe onset of symptoms: _____

Indicate dates of hospital confinement (if any): _____

List completed diagnostic tests: _____ date : _____

List pending diagnostic test: _____ date : _____

test: _____ date : _____

If referred to a specialist-name: _____ date : _____

List all of your current complaints: _____

_____

Medications prescribed: _____ Pharmacy name & address: _____

_____ _____

Have you ever had a similar condition? Yes ____ No ____

If "yes" please provide dates and details (diagnosis and names of treating doctors):

_____

_____

_____

Have you had any prior absences from work due to medical reasons that lasted longer than 10 consecutive days? Yes ____ No ____

If "yes" please provide date(s) of absences: _____

_____

_____

Reason for absence(s): _____

_____

If you had an accident, complete the following: _____

Describe details of the accident: _____

Date: _____ Time: _____ Location: _____

To whom was this accident reported? _____

Is this accident work related? _____

Date/time of first treatment: _____ Place: _____

Other Insurers/Compensation or Benefit Agencies involved: _____

_____

"**If motor vehicle accident**, provide copy of the police accident report."

DISABILITY

I have not worked since: _____

What physical restriction and limitations currently prevent you from doing any or some of your usual daily duties:

_____

Expected return to work date – partial work: _____ full work: _____

If you expect to return to work on modified or part-time basis, please list the duties you will be performing:

_____

What duties will you be unable to perform: _____

_____

Have you hired help for your business? Please provide names and contact information:

_____

Have you hired assistance for personal care, home maintenance or other?

Please provide details: _____

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OTHER INSURANCE COVERAGE AND INCOME REPLACEMENT

Have you applied for any other benefits or do you have income from any other source(s): Yes ____ No ____
Complete the section below.

Sources of Income	Yes / no	Company name and policy #	Amount of benefits Per week/month	Date benefits began	Date benefits ended
Salary continuation					
Union					
Short term DI (Group)					
Long term DI (Group)					
Employment Ins.					
CPP/QPP Disability					
CPP/QPP Retirement					
Workers Comp.					
Auto Insurance					
Retirement Pension Plan					
Individual Disability Coverage					
Credit/Loan Ins					
WOP on life					
Others					

ANY PERSON WHO KNOWINGLY FILES A CLAIM REPORT CONTAINING MISLEADING OR FALSE INFORMATION MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES

I declare that the information I have provided herein is true and complete to the best of my knowledge.

Name: _____ Date: _____

Address: _____

Please attach any other information that supports your claim.

AUTHORIZATION

I HEREBY AUTHORIZE La Capitale Financial Security Insurance Company, its authorized agents and reinsurers, for file management and claim settlement purposes only: a) to gather all information necessary for claim settlement and the management of my file from any person, organization or public or parapublic institution holding personal information about me, notably from health professionals and health centres, the MIB, LLC., financial institutions, Government agencies, Provincial Workers Compensation Organization, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, employers or previous employers; b) to disclose to such individuals and organizations only that personal information it has relating to me that is relevant to my file or that is required by law; c) to request an investigation report relating to me. A photocopy of this authorization shall be as valid as the original. This authorization is valid for the period required to achieve the purpose for which it was requested.
I acknowledge that the Company may refuse to consider my claim if I do not comply completely with this authorization.

Insured's first and last name in printed letters: _____

Insured Sign Here: _____ Witness Sign Here: _____

Address: _____ Address: _____

City, Prov., Postal Code: _____ City, Prov., Postal Code: _____

Date: _____ Date: _____

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PATIENT'S NAME	
DATE OF BIRTH	

PART B ATTENDING PHYSICIAN'S REPORT

Patient's name: _____ D.O.B.: _____ My patient since: _____

Diagnosis of Current Disability: _____

Other Diagnosis or Concurrent conditions: _____

_____

Describe how any other conditions affect treatment/recovery: _____

_____

Date symptoms first appeared or accident happened :

_____

Please provide initial and subsequent dates of treatment for this condition :

_____

Please describe history of presentation/complaints including mechanism of injury (if applicable):

Accident ☐ _____

Disease ☐ _____

Gradual and/or Progressive ☐ _____

Clinical Presentation and Objective Findings (please include type of tests, dates performed, results and copies):

_____

_____

We need to understand how HARM vs. HURT applies to this situation:

What are the patient's restrictions (what the patient SHOULD NOT do) and why? _____

_____

_____

What are the patient's limitations (what the patient CANNOT do) and why? _____

_____

_____

Has patient ever had same or similar condition? If yes, please state when and provide details: _____

_____

_____

If treated by another physician for this condition, please provide name, specialty and address: _____

_____

_____

Please summarize their findings or provide copies: _____

_____

_____

Nature of surgical procedure done or planned: _____

Date performed/date booked: _____

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Please describe nature and duration of treatment (ie. surgery, physiotherapy, rehab programs, etc):

Please complete if applicable:

	Name	Address	Dates
Hospital			
Rehab Centre			
Physiotherapy			
Long Term Care			
Adult Day Care			
Other			

Please complete if applicable:

Medication	Dosage	Date Started	Response/Side Effect	Date Stopped or Modified

Is your patient: Employee ☐ Self employed ☐ Retired/Unemployed ☐

Please describe the occupational duties and/or activities as known to you:

If unemployed/retired, please indicate a reasonable period of recovery:

No activity from _____ to _____

Partial activity from _____ to _____

If Employee/Self Employed, please indicate:

How long was/will your patient (be) totally disabled (unable to work) from _____ to _____

How long was/will your patient (be) partially disabled (able to perform some but not all their occupational duties):

from _____ to _____

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DATE OF BIRTH	

Names of other insurers, compensation or Government agencies you are reporting to:

Are there any barriers that may interfere with your patient's ability to return to work e.g.: job, family, stressors, etc.:

Please provide us with any information you feel would assist us in understanding your patient's condition:

Remarks:

Is patient still under your care: Yes ☐ No ☐ If no, as of what date?

Identification of physician

Last name, first name:

Address: Tel:

Fax:

License No.:

General practitioner ☐ Specialist ☐ Specify:

Signature: Date: A | A | A | A | M | M | J | J

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.

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