La Capitale

TOTAL DISABILITY INSURED'S STATEMENT

Insured's last name | Insured's first name

Date of birth: Year Month Day Sex: ☐ F ☐ M

Contract No. | Client No.

When disclosing medical and health information, the results of any genetic test should not be included.

1 Insured's occupation: ______

2 Name and telephone number of employer's resource person: ______ Area code Telephone No.

3 Start of disability: Year Month Day

4 Last day worked: Year Month Day

5 Is the insured still totally disabled? ☐ Yes ☐ No – **If not,** end date of disability: Year Month Day

6 Has the insured worked part-time since the start of disability? ☐ Yes ☐ No

If so, how many days or hours per week? ______

7 Return to full-time work: Year Month Day

8 Gradual return to work: Year Month Day

9 Cause of disability: ______

10 If disability was the result of an accident, describe the circumstances: ______

11 If disability was the result of an illness, has the insured already experienced this illness or a similar illness? ☐ Yes ☐ No

If so, provide the details and the dates of tests, examinations and treatments: ______

TOTAL DISABILITY INSURED'S STATEMENT

12 Name and address of the insured's family physician:

Name of physician

Address (No., street, city, province)

Postal code

13 Names and addresses of other physicians consulted:

Name	Address	Date of consultation
		Year Month Day
		Year Month Day
		Year Month Day

14 Names and addresses of hospitals or institutions where the insured was treated or hospitalized:

Name (hospital or institution)

Address (No., street, city, province)

Postal code

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

Name (hospital or institution)

Address (No., street, city, province)

Postal code

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

Name (hospital or institution)

Address (No., street, city, province)

Postal code

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

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15 Does the insured take medication? ☐ Yes ☐ No – **If so:**

Name of medication	Dosage

16 Does the insured smoke cigarettes or used any form of tobacco or nicotine (including marijuana/cannabis containing any tobacco or nicotine product) or used a substitute (nicotine gum or patch), electronic cigarette or vape device? ☐ Yes ☐ No

If so:

Since what date has the insured smoked? ______ Year Month Day

Daily use: ______

If not:

Did the insured previously use tobacco? ☐ Yes ☐ No

If so, what date did the insured quit: ______ Year Month Day

17 Has the insured or is the insured planning to submit a claim regarding this illness to a public agency such as Retraite Québec, CNESST, SAAQ, another insurance company or both? ☐ Yes ☐ No – **If so:**

Name of the agency or insurance company	File number	Claim already submitted	Date of the claim	Status of the claim
		☐ Yes ☐ No	Year Month Day	☐ Approved ☐ Denied ☐ Under assessment
		☐ Yes ☐ No	Year Month Day	☐ Approved ☐ Denied ☐ Under assessment
		☐ Yes ☐ No	Year Month Day	☐ Approved ☐ Denied ☐ Under assessment

18 Additional information: ______

INSURED'S STATEMENT

I acknowledge and agree that the answers given in this form are true and complete.

Signed at ______ on this ______ day of ______ 20 ______ .

Signature of insured

______ Address (No., street, apt., city, province) ______ Postal code

______ Area code ______ Home tel. ______ Area code ______ Work tel. ______ (ext.)