Assumption Life

CLHIA ACCAP

Plan Member Confirmation of Illness Form

Please only complete this form if your absence is due to symptoms of COVID-19 and you're pending test results, or if you have a clinical diagnosis of COVID-19.

In recognition of the increasing pressure on our medical clinics and hospitals due to the COVID-19 pandemic, we will not, at the outset, require an Attending Physician's Statement as part of your disability claim submission if your absence is due to COVID-19 symptoms, or a clinical diagnosis of the virus. This is a time limited exception as we move through the current situation.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms, your test results, and any medical treatment you may have received for your condition. Accordingly, please complete and sign this form and return it with your Plan Member Statement to the email lifedisability@assumption.ca.

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1. Please confirm:

Policy number: _____ Certificate Number: _____

Plan Member Name: _____ Plan Sponsor Name: _____

Date symptoms first appeared: _____
(dd/mm/yyyy)

First day absent from work: _____
(dd/mm/yyyy)

2. Please indicate the symptoms associated with your illness:

- ☐ Fever
- ☐ Cough
- ☐ Fatigue
- ☐ Muscle aches
- ☐ Sore throat
- ☐ Shortness of breath
- ☐ Other _____
- ☐ Decreased appetite
- ☐ Runny nose
- ☐ Nausea
- ☐ Vomiting
- ☐ Headache

3. Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)?

4. A) Date of medical consultation relating to COVID-19: _____ (dd/mm/yy)

B) Who was the medical consultation with (e.g.: physician/clinic/hospital/Public Health authority)?

_____

5. A) Date of COVID-19 test: _____ (dd/mm/yyyy)

B) Name, address and phone number of facility where test conducted.

_____

C) Test result:

- ○ Positive
- ○ Negative
- ○ Pending - if pending, date expected: _____ (dd/mm/yyyy)

Attach test results if available.

6. Have you been instructed to quarantine?

- ○ Yes, as of this date: _____ (dd/mm/yyyy)
- ○ No

- When do you expect the quarantine to end? _____ (dd/mm/yyyy)
- When are you next seeing your physician? _____ (dd/mm/yyyy)
- When do you expect to return to work? _____ (dd/mm/yyyy)
- Can you work from home? ◉ Yes ○ No

7. Any other details relating to your illness you'd like us to know:

_____

I certify that the statements in this form are true and complete and understand that further information may be required to validate my claim.

Name: _____ Phone #: _____ Cell #: _____

Email _____

Signature: _____ Date: _____

Have questions about your claim? Contact the Customer Contact Center at 1-855-244-7011.

For more information on the novel coronavirus, go to the Public Health Agency of Canada's website at https://www.canada.ca/en/public-health.html

Assumption Life
Group Insurance

Disability Claim (Initial Request) Employee's Statement

Type of claim: ☐ **Short-Term Disability** ☐ **Long-Term Disability** ☐ **Waiver of Premium**

To ensure prompt processing, please answer all questions and obtain all required signatures.

First Name _____ Last Name _____ Policy _____ Division _____ Certificate _____

Social Insurance Number _____ Language: ☐ French ☐ English ___ / ___ / _____ Date of birth (DD/MM/YYYY) Gender: ☐ F ☐ M

Address _____ City _____ Province _____ Postal Code _____

Fax _____ E-mail _____

Telephone - Home _____ Telephone – Work _____ Telephone - Cell _____

Section 1 General Information

Training: _____
Level of education: _____
Work experience: _____

Spoken language: ☐ French ☐ English
Written language: ☐ French ☐ English

If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy Number	Certificate Number	Date Benefits Commenced (DD/MM/YYYY)	Benefit Period (DD/MM/YYYY)	Benefit Amount	Weekly or Monthly
			___/___/_____	___/___/_____ to ___/___/_____	$	☐ W ☐ M
			___/___/_____	___/___/_____ to ___/___/_____	$	☐ W ☐ M
			___/___/_____	___/___/_____ to ___/___/_____	$	☐ W ☐ M

Section 2 Reason for the Claim

1. If the sick leave was the result of an accident, indicate:

A) Place of the accident: ☐ Home ☐ Work ☐ Elsewhere (specify) _____

B) Date of the accident: (DD/MM/YYYY) ___ / ___ / _____

C) Circumstances: _____

_____

_____

_____

_____

_____

_____

_____

D) If a car accident, specify whether you were: ☐ the driver ☐ a passenger <u>If not a Quebec resident, please submit the police report.</u>

2. Is your current absence from the workplace due to work-related issues? ☐ Yes ☐ No Please elaborate: _____

_____

_____

_____

_____

_____

_____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 E-mail: lifedisability@assumption.ca

Assumption Life
Group Insurance

Name of employee: _____

Section 3 Occupation

Date hired: (DD/MM/YYYY) ___ / ___ / _____ When did you become unable to work? (DD/MM/YYYY) ___ / ___ / _____

1. Explain how your condition is preventing you from working. _____

2. Describe the duties of your job that you can no longer perform. _____

3. When you stopped working, were you working elsewhere (second job)? ☐ Yes ☐ No If yes, specify: _____

Section 4 Current Situation

1. A) Are you confined to your home? ☐ Yes ☐ No
   B) Are you confined to your bed? ☐ Yes ☐ No
   C) Are you hospitalized? ☐ Yes ☐ No

2. Please describe all your symptoms, including severity and frequency. _____

3. Describe your current activities of daily living since going on sick leave. _____

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Assumption Life
Group Insurance

Name of employee: _____

Section 5 Income from Other Sources

1. Are you currently performing any work, even part-time, for which you receive any form of compensation? ☐ Yes ☐ No

2. Please indicate your entitlement to Disability Benefits, Income Replacement or waiver of payments from these sources as a result of your current health problem.

Source	Applied	Intend to Apply	Date of Claim Submission (DD/MM/YYYY)	Benefit Commencement Date (DD/MM/YYYY)	Amount and Frequency of Payment
Canada/Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Retirement Income/ Social Security	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
WSIB/WCB/CSST	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Employment Insurance Canada	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Car Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
War Veteran's Disability Pension	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Group Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Individual Life or Disability Insurance Income	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	
Other (specify): _____	☐ Yes ☐ No	☐ Yes ☐ No	___ / ___ / _____	___ / ___ / _____	

PROVIDE A COPY OF CORRESPONDENCE CONFIRMING BENEFIT PAYMENT.

Section 6 Physicians and History

1. Name of you attending physician: _____ Date of initial visit: (DD/MM/YYYY) ___ / ___ / _____
   Address: _____
   Telephone: _____ Fax : _____

2. Have you been hospitalized for this medical condition? ☐ Yes ☐ No Date: (DD/MM/YYYY) ___ / ___ / _____
   Name of Hospital: _____ Location: _____

3. When did your symptoms begin? _____
   _____
   _____

4. When did you first consult a physician for this medical condition? _____

5. Have you ever had a similar illness or injury before? ☐ Yes ☐ No Date: (DD/MM/YYYY) ___ / ___ / _____

6. Would you be able to return to work gradually? ☐ Yes ☐ No

7. Has your attending physician prescribed medication? ☐ Yes ☐ No If yes, are you taking it regularly? ☐ Yes ☐ No

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Group Insurance

Name of employee: _____

Section 6 Physicians and History (continued)

8. List all the physicians who have treated you in the last two years.

Illness	Consultation or treatment date	Treatment prescribed, medication, other	Name of Physician	Address of physician
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			
	___ / ___ / _____			

Section 7 Employee s Authorization & Acknowledgement

I certify that the information given on this form is true, correct and complete.

For purpose of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize Assumption Life, its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), workers compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of myself, to give to Assumption Life full particulars of such information, including, without limiting the generality of the foregoing, any information regarding my lifestyle, health, prior medical history and benefits.

I transfer and assign to Assumption Life, and agree to pay and refund to Assumption Life those disabilities and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Workers' Compensation, and other insurance policies.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or any professional organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating such fraud or abuse.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

_____

Name (in block letters)

_____ _____

Employee's Signature Date (DD/MM/YYYY)

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