Plan Member Confirmation of Injury/Illness Form – New Claim

In recognition of the increasing pressure on our medical clinics and hospitals due to the COVID-19 pandemic, we may not, at the outset, require an Attending Physician's Statement as part of your new disability claim. Please complete this form only in the event you were unsuccessful in having your health professional complete one, or if you were unable to consult with your health professional. This is a time limited exception as we move through the current situation. Please note however, we reserve the right to request further medical information depending on the information provided below.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms, any test results, and any medical treatment you may have received for your condition.

Once the form is completed, send it along with the *Claim Form - Disability Insurance* duly completed by you and the *Administrator's Statement* duly completed by your employer to one for the following addresses:
- residents of Quebec: salaire@ssq.ca
- residents of other provinces in Canada: disabilitymanagement@ssq.ca

Member Details

Group Number: _____ Certificate Number: _____

Employee Name: _____ Plan Sponsor Name: _____

New Claim - Non COVID-19 Diagnosis

1. For illness - date symptoms first appeared: Year Month Day

   For injury – date of accident/injury: Year Month Day

2. First day absent from work: Year Month Day

3. What has prompted you to stop working?

4. Did you consult with a health professional for your injury/symptoms and work absence? ☐ Yes ☐ No

   If yes, please provide information about this health professional

   Name: _____ Location: _____ Phone: _____

   Specialty: _____

   What date did you consult this health professional? Year Month Day

   If no, please provide details as to why you did not seek medical attention for your condition:

5. Please provide any current test results. Please also provide additional details if you have an upcoming tests or other appointments (i.e. specialist) scheduled regarding this condition? Please elaborate:

6. Please list symptoms you are experiencing associated with your illness/injury and the severity of each symptom. Please describe how your symptoms are currently impacting your ability to work:

7. Please provide details about what you have discussed with your employer regarding how you could be accommodated, including work from home?

8. Do you have an anticipated return to work date? ☐ Yes ☐ No If so, when: Year Month Day

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

10. Diagnosis

Primary: _____

Secondary and/or complications: _____

If Childbirth - Expected or Actual Delivery Date: Year Month Day ☐ Vaginal ☐ C-Section

11. Is your condition related to an Occupational Illness/injury? ☐ Yes ☐ No If yes, date of event: Year Month Day

12. Is your condition related to an Auto accident? ☐ Yes ☐ No If yes, date of event: Year Month Day

13. Have you been hospitalized for this condition? ☐ Yes ☐ No Date of admittance Year Month Day

***If you have been hospitalized for this condition, please provide any documents you received upon discharge.

14. Date of discharge Year Month Day Name of the Institution _____

15. Have you had surgery for this condition? ☐ Yes ☐ No If yes, please provide date and description of surgery

Date Year Month Day Description: _____

16. Treatment description (i.e. medication, dosage)

17. Have you had therapy for your condition? ☐ Yes ☐ No

If yes, please provide information about your therapist

Name: _____ Address: _____ Phone: _____

Specialty: _____

What date did you see your therapist? Year Month Day

Have you continued to receive therapy from this provider, including virtual therapy, since March 2020? ☐ Yes ☐ No

Please elaborate:

18. Have you been treated for this same or similar condition in the past? ☐ Yes ☐ No If yes, date:

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

We reserve the right to pursue recovery of benefits improperly paid for any reason, fraud or otherwise. The submission of fraudulent claims is a criminal offence and is taken seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

Please note that the authorization you signed on the Application for Disability Insurance Benefits form is also applicable to this document.

Name: _____ Phone Number: _____

Email: _____ Cell Phone Number: _____

Signature: _____ Date: Year Month Day

Have questions about your claim? Contact the Customer Centre at 1-888-651-2307 for Quebec customers and 1-866-885-6772 for customers outside the province of Quebec.

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