SSQ Financial Group

Values in the right place

DISABILITY
CLAIMANT'S STATEMENT

SSQ Insurance Company Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

INSTRUCTIONS
Fill out the claimant's statement and sign the authorizations.
All costs incurred are at the claimant's expense.

POLICY Nº.

Identification of the Claimant

Surname and first name

Name at birth

Address

Province

Postal code

Sex: ☐ F ☐ M

Date of birth (Y Y Y Y M M D D)

Home phone

Work phone

Profession or occupation

$ Net monthly income from your occupation

Employer's name and address

Telephone

Information Related to Disability

Does it involve: ☐ a motor vehicle accident ☐ a work accident ☐ an illness ☐ a fall ☐ other:

Date of the accident *if applicable* (Y Y Y Y M M D D)

Date of the start of illness leading to disability (Y Y Y Y M M D D)

Describe the circumstances of the accident

Type of injury or illness

Date of work stoppage, *if applicable*, or onset of disability (Y Y Y Y M M D D)

Date of return to work or to normal occupations
☐ indeterminate ☐ expected on: (Y Y Y Y M M D D)

Indicate the daily activities you are incapable of performing

Name and address of your family doctor over the last five (5) years

Have you stayed at a hospital or other health care facility? (Full name and address)
☐ No ☐ Yes *If yes, which one?*

Period in hospital:
From: (Y Y Y Y M M D D) to: (Y Y Y Y M M D D)

Have you applied for benefits from the following authorities: *(if yes, attach the notice of acceptance or refusal)*	Yes	No	Date of application	Was your application accepted? Yes	No	Under study	Monthly amount	Duration (Limited period)
Provincial pension plan	☐	☐	Y Y Y Y M M D D	☐	☐	☐	$	
Canada Pension Plan	☐	☐	Y Y Y Y M M D D	☐	☐	☐	$	
Provincial automobile insurance plan	☐	☐	Y Y Y Y M M D D	☐	☐	☐	$	
Workplace health and safety commission	☐	☐	Y Y Y Y M M D D	☐	☐	☐	$	
Another disability insurance plan (individual or group)	☐	☐	Y Y Y Y M M D D	☐	☐	☐	$	

If your application was accepted, name of the company

Policy Nº.

If your application was refused, explain why

Do you have other sources of income?
(If yes, indicate amounts, periods and sources)
☐ No ☐ Yes *If yes, please specify:*

Amount
$

Period
from: (Y Y Y Y M M D D) to: (Y Y Y Y M M D D)

I STATE THAT THE ANSWERS ABOVE ARE COMPLETE AND TRUTHFUL.
ALL COSTS INCURRED IN FILLING OUT THE FORM ARE AT THE CLAIMANT'S EXPENSE.

X

Claimant's Signature

Date (Y Y Y Y M M D D)