SSQ Financial Group

Values in the right place

Physical Illness Additional report

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

General Information (section to be completed by the insured)

Family name _____ Name _____

Contract no.: _____ Social Insurance Number _____ Date of birth (Y Y Y Y M M D D)

Declaration of the attending physician (complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Objective elements of the physical examination and investigation (attach copy of recent results, X-rays, ECG, or other tests or examinations): _____

Weight _____ lb ☐ kg ☐ Height _____ ft/in ☐ m/mc ☐ Most recent blood pressure: _____

1.4 Degree of the symptom's severity: (M = mild, Md = Moderate, S = Severe)

_____ ☐ M ☐ Md ☐ S _____ ☐ M ☐ Md ☐ S

_____ ☐ M ☐ Md ☐ S _____ ☐ M ☐ Md ☐ S

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 Additional treatments (specify the type and frequency): _____

2.3 Surgery (date, nature and procedure): _____

2.4 Hospitalization: from (Y Y Y Y M M D D) to (Y Y Y Y M M D D) Name of hospital: _____

2.5 Consultation with specialist: ☐ No ☐ Yes **if yes, please attach copy**

3. Follow-up and prognosis

3.1 Date of last consultation: (Y Y Y Y M M D D) Next consultation: (Y Y Y Y M M D D)

3.2 Tests and examinations to come: _____ 3.3 Frequency of follow-up: _____

3.4 Referral to a specialist: ☐ No ☐ Yes Name of physician: _____

3.5 Scheduled date of consultation with a specialist: (Y Y Y Y M M D D) Speciality: _____

3.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities

At the beginning of disability	Currently

3.7 Evolution: ☐ progressive ☐ stable ☐ regressive

3.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis: _____

3.9 Patient's cooperation in the treatment: ☐ excellent ☐ average ☐ poor 3.10 Would the patient benefit from assistance within the scope of a return to work? ☐ No ☐ Yes

3.11 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ ☐ Unspecified or date of return to work: (Y Y Y Y M M D D)

3.12 How long before the patient will be able to return to work? No. of days: _____ No. of weeks: _____

☐ part-time ☐ full-time ☐ gradual return Specify: _____

4. Questions specific to the contract

_____

_____

5. Identification of the physician

5.1 Family name, given name _____ Telephone : _____ Fax: _____

5.2 License number : _____ ☐ General practitioner ☐ Specialist Specify: _____

X _____ (Y Y Y Y M M D D)

Signature Date

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM

SSQ Financial Group

Values in the right place

Psychological Illness Additional report

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

General Information (section to be completed by the insured)

Family name | Name

Contract no.: | Social Insurance Number | Date of birth (Y Y Y Y M M D D)

Declaration of the attending physician (complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal:

1.2 Secondary:

1.3 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity: (M = mild, Md = Moderate, S =Severe)

Signs	M	Md	S	Symptoms	M	Md	S
.....	☐	☐	☐	.....	☐	☐	☐
.....	☐	☐	☐	.....	☐	☐	☐
.....	☐	☐	☐	.....	☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage:

2.2 Is the patient consulting:	No	Yes	Since when?	Is the patient treated in:	No	Yes	Specify:
a psychiatrist	☐	☐	Y Y Y Y M M D D	a treatment centre	☐	☐	
a psychologist	☐	☐	Y Y Y Y M M D D	a CLSC	☐	☐	
a social worker	☐	☐	Y Y Y Y M M D D	a day hospital	☐	☐	
an other caregiver	☐	☐	Y Y Y Y M M D D	group therapy	☐	☐	
				individual therapy	☐	☐	

AXE II) Associated personality disorders: ☐ No ☐ Yes Specify:

Associated drug addiction, alcoholism or gambling problems: ☐ No ☐ Yes Specify:

AXE III) Associated illness: — diagnosis:

— drugs prescribed:

AXE IV) Associated psychosocial stress factors (in the last 12 months):

☐ Personal or interpersonal problems ☐ Loss of employment or layoff ☐ Professional problems

☐ Marital/family life ☐ Alcohol or drug abuse or gambling problems

☐ Other problems, specify:

3. Follow-up and prognosis

3.1 Date of last consultation: (Y Y Y Y M M D D) Next consultation: (Y Y Y Y M M D D)

3.2 Follow-up frequency:

3.3 Will the patient be referred to a psychiatrist? ☐ No ☐ Yes Name of physician:

3.4 Patient's cooperation in the treatment: ☐ excellente ☐ average ☐ poor

3.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis:

3.6 Would your patient benefit from assistance within the scope of a return to work? ☐ No ☐ Yes

3.7 Do you consider that the patient's condition has improved in an optimal way? ☐ No ☐ Yes

3.8 Approximate duration of disability: No. of days: No. of weeks: ☐ Unspecified or date of return to work: (Y Y Y Y M M D D)

3.9 How long before the patient will be able to return to work? No. of days: No. of weeks:

☐ part-time ☐ full-time ☐ gradual return Specify:

4. Questions specific to the contract

5. Identification of the physician

5.1 Family name, given name Telephone : Fax:

5.2 License number : ☐ General practitioner ☐ Specialist Specify:

X

Signature | Date (Y Y Y Y M M D D)

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM