NATIONAL BANK
INSURANCE
800 Saint-Jacques Street, office 43511, Montreal, Quebec H3C 1A3
Telephone: 514-871-7500 or 1-877-871-7500 - Fax: 1-866-394-6340

CLAIM REQUEST
DISABILITY INSURANCE
Insured's statement

IDENTIFICATION OF THE INSURED

First name _____ Last name _____ Date of birth (YYYY MM DD) _____ Gender: ☐ M ☐ F

INSURED'S STATEMENT

To prevent delays in processing your claim, please answer all questions in as much detail as possible.

A. GENERAL INFORMATION

1. Address (No., street, city, province, postal code) _____

Telephone No. (home) _____ Telephone No. (other) _____

2. Name, address and telephone number of your family physician:

First and last name of your family physician _____ Telephone No. of your family physician _____

Address of your family physician (No., street, city, province, postal code) _____

a) How long has he/she been your family physician? (YYYY MM DD): _____

3. Indicate whether you are ☐ right-handed or ☐ left-handed.

4. Do you currently use tobacco or marijuana, or a nicotine replacement product in any form whatsoever?

☐ No ☐ Yes If yes, specify: ☐ tobacco ☐ marijuana ☐ nicotine replacement product

a) If not, have you ever used these substances?

☐ No ☐ Yes If yes, specify: ☐ tobacco ☐ marijuana ☐ nicotine replacement product

Specify the date on which you stopped using the substance (YYYY MM DD): _____

B. CLAIM REQUEST INFORMATION

5. Did you stop working because of: ☐ an illness ☐ an accident

a) If it was due to an accident, please specify the following:

Where: _____

When (YYYY MM DD): _____

How (description): _____

b) Did you submit a claim to:

☐ Workers' Compensation Board ☐ Quebec Pension Plan (QPP) ☐ Employment Insurance (EI)

☐ Provincial automobile insurance ☐ Canada Pension Plan (CPP)

☐ Other government agency, specify: _____
Name of agency

☐ Other insurer/salary insurance:

Name of the insurance company _____ Your file No. _____

First and last name of the individual in charge of your file _____ Contact information of the individual in charge of your file _____

6. Describe your symptoms (intensity, frequency, duration, time of the day):

a) When did these symptoms first appear? (YYYY MM DD) _____

7. When did you first consult a physician for your present condition? (YYYY MM DD) _____

8. Provide the names, addresses and phone numbers of all physicians consulted for this condition and the dates of consultations:

9. What treatment have you received?

10. Specify any medical exams with the dates and results of these exams. Attach copies of the results (if available), copies of consultations with specialists and any other relevant document:

11. Are you taking medication (related or not to the current condition)? ☐ No ☐ Yes

a) If so, indicate the name of the medication, dosage and how long you have been taking this medication:

12. Date of last day worked because of your illness, injury or accident (YYYY MM DD): _____

13. Were you hospitalized? ☐ No ☐ Yes

If yes, specify: Date admitted (YYYY MM DD): _____ Date discharged (YYYY MM DD): _____

a) _____ _____

Name of the hospital | Address of the hospital (No., street, city, province, postal code)

14. Describe your daily activities **before** you stopped working:

15. Describe your daily activities **since** you stopped working:

16. Have you had the same or a similar illness or injury before? ☐ No ☐ Yes

a) If so, give details including the names, addresses and telephone numbers of the physicians consulted and the dates of consultations:

17. Do you know when you expect to return to work? ☐ No ☐ Yes

If yes, please indicate the date (YYYY MM DD): _____

C. INFORMATION ON HEALTH PROFESSIONALS

18. List all of the health professionals (including family physicians, specialists, chiropractors, physiotherapists, psychologists, etc.) you have consulted and who have treated you during the **last five (5) years, starting with the most recent. Indicate the reasons for consultations whether or not they are related to your current condition. Also indicate if you have not consulted any professional.** (If the space provided below is insufficient, please attach another sheet of paper, being sure to sign and date it.)

Names, addresses, telephone and fax numbers of the physicians or other health professionals	**Consultation or treatment dates** (YYYY MM DD)	**Reason for consultation**	**Treatment received** (medication, physiotherapy, chiropractic care, rest, surgery, etc.)

D. INFORMATION ON CURRENT EMPLOYMENT

If you are self-employed, go to section E and then answer all questions on the "Statement of employer or self-employed worker" form (F.29548-502).

19. Date hired (YYYY MM DD): _____

20. Name of company: _____

_____

Address (No., street, city, province, postal code)

_____ _____ _____

Telephone No. Fax No. First and last name of the contact person

21. Occupation (title): _____

22. Describe the main duties of your position:

_____

_____

_____

a) Are you able to resume some of the duties listed above? ☐ No ☐ Yes

Specify: _____

_____

_____

23. Indicate the percentage of tasks that require physical effort _____ are administrative tasks _____

a) Indicate how many times a day you do the following actions:

LIFTING (including pushing or pulling while staying in one place)

- ☐ 1 - 10 lbs (0.5 to 4.5 kg) : _____
- ☐ 10.1 - 25 lbs (4.6 to 11.3 kg) : _____
- ☐ 25.1 - 50 lbs (11.4 to 22.7 kg) : _____
- ☐ 50.1 lbs or more (22.8 kg or more): _____

CARRYING (including pushing or pulling while walking)

- ☐ 1 - 10 lbs (0.5 to 4.5 kg) : _____
- ☐ 10.1 - 25 lbs (4.6 to 11.3 kg) : _____
- ☐ 25.1 - 50 lbs (11.4 to 22.7 kg) : _____
- ☐ 50.1 lbs or more (22.8 kg or more): _____

b) Indicate what percentage of your work day involves each action/element:

Occasionally (O): 0-15% of the time / Frequently (F): 16-50% of the time / Continually (C): 51% of the time or more

O/F/C		O/F/C	
_____	Sitting	_____	Working with others
_____	Standing	_____	Using manual dexterity
_____	Walking	_____	Reaching **below** shoulder height
_____	Walking on uneven or slippery terrain	_____	Reaching **above** shoulder height
_____	Crouching	_____	Working outside
_____	Kneeling	_____	Working inside
_____	Climbing (ladders)	_____	Working in a humid environment
_____	Experiencing vibrations	_____	Working in extremes of cold or heat
_____	Bending	_____	Working around toxic fumes

E. EDUCATION AND EXPERIENCE

24. What is the highest level of education you have completed? _____

25. Describe your work experience:

_____

_____

_____

INSURED'S SIGNATURE

I, the undersigned, certify that the statements made in this document are true and complete.

_____ **X** _____

Date (YYYY MM DD) Signature

Please sign and date any document that you attach.
NOTE: You must pay any fees your physician charges to complete forms.