UNIVERSITÉ Concordia UNIVERSITY

SHORT-TERM DISABILITY CLAIM FORM

EMPLOYEE'S STATEMENT *(Please Print)*

Employee's Name (Last, first)

Date of Birth Month / Day / Year

Sex ❒ Male ❒ Female

Address

Social Insurance Number

Name of Attending Physician (Please print)

Home Phone Number ( )

Date of Expected Return to Work Month / Day / Year

If disability due to an accident, please indicate:

- Date and time of accident: Month / Day / Year at _____ A.M. ❒ P.M. ❒
- Did accident occur at work? Yes ❒ No ❒
- Brief description of accident: _____

Has or will a claim be filed for Workers' Compensation or Québec Auto Insurance Yes ❒ No ❒

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

Name of Insurer	Policy No.	Certificate No.	Date Benefits Commence	Benefit Period	Benefit Amount	Weekly Monthly
						❒ W ❒ M
						❒ W ❒ M

COMMENTS: I hereby certify that the above answers are full and true to the best of my knowledge and belief.

Employee's signature **Date**

Authorization for the collection and communication of personal information

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and setting my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals of facilities, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, the policyholder, my employer of former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. I authorize Desjardins Financial Security Life Assurance Company to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

Employee's signature **Date** **SIN No.**

VERY IMPORTANT: Please have the declaration of the attending physician–original request completed, and forward completed forms to Desjardins Financial Security Life Assurance Company, Disability claims.

EMPLOYER'S STATEMENT *(Please Print)*

Policy No.: **Q057 - Concordia University**

Date Claim Received by Insurer: Month / Day / Year

For tax purposes please indicate:

- Province in which employee is taxed _____
- Amount of federal exemption $_____
- Amount of provincial exemption $_____

Control number (to be completed by insurer)	Teaching contract	Average weekly salary*	Date contract started Month Day Year	Date contract ends Month Day Year
_____	1st	_____	____/____/____	____/____/____
_____	2nd	_____	____/____/____	____/____/____
_____	3rd	_____	____/____/____	____/____/____
_____	4th	_____	____/____/____	____/____/____
_____	5th	_____	____/____/____	____/____/____

* *Average weekly salary = 108% of total contract value divided by total number of weeks in contract*

First day of absence Month / Day / Year

Last day paid by Concordia Month / Day / Year

Date returned to work Month / Day / Year

Is employee entitled to disability income benefits under any government legislation, including Workers' Compensation or Provincial Auto Insurance?

Yes ❒ No ❒ If "yes", please explain _____

If this claim relates to maternity, please give date of maternity leave: From Month / Day / Year to Month / Day / Year

Date **Concordia University (Authorized signature)**