

SHORT-TERM DISABILITY CLAIM FORM

Address Month Day Year Male Female	1	Sex	(
Social Insurance Number Nu				male
Number Name of Attending Physician Passage price			□ Male □ Tel	illaic
Name of Attending Physician Phase Date of Expected No. N)	1	
Phase prints Phas	Number			
Some Phone Number		ng Physician		
February				
If disability due to an accident, please indicate: Date and time of accident: Did accident occur at work? Brief description of accident: Brief description of Quebec Auto Insurance Yes		d Month	Day Year	
- Did accident occur at work? - Brief description of accident: Prior lave any accident or solutes coverage through a union, society, creditor, mortgage, auto, lodge or other association or through union, corety, creditor, mortgage, auto, lodge or other association or through unions creditory, and a policy No. Remarks Policy No. Certificate No. Date Benefits Commence Benefit Period Benefit Amount Month		Day Year		
Has or will a claim be filed for Workers' Compensation or Québec Auto Insurance If you have any accident ut sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association or through mother employer or under an individual policy, give the following particulars: Name of Insurer Policy No. Certificate No. Date Benefits Commence Benefit Period Benefit Amount Weekt Meriod Authorization for the collection and communication of personal information authorization for the collection and communication of personal information authorization for sources from which information may be collected include benefits comparation, only the information deemed accessary to manage my fife and setting my claims to; (a) collect from any person or legal entity, or from any public or parapulsic organization, only the information deemed accessary to manage my fife and setting my comparation, collected from any person or legal entity, or from any public or parapulsic organization, only the information deemed accessary to manage my fife and setting my comparation, collected from any person or legal entity, or from any public or parapulsic organization, only the information may be enabled any comparation of the collected from the benefits of prometric maphyses. No communicate to the said personal and also use the premount information in trans the map have about me in existing files that are now closed. Industrial in a final and also use the premount information in trans the natural have about an ensuing the submitted prometric maphyses. A photocopy of this authorize Designidars infanced Security Life Assurance Company, Disability claims. Employee's signature Date In the province in which employee is taxed. Amount of provincial exemption S Policy No. Q057 - Concordia University Date Claim Received by Insurer; North Day North	lent:		at A.M. 🗖	Р.М. 🗖
Has or will a claim be filed for Workers' Compensation or Québec Auto Insurance If you have any accident ut sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association or through mother employer or under an individual policy, give the following particulars: Name of Insurer Policy No. Certificate No. Date Benefits Commence Benefit Period Benefit Amount Weekt Meriod Authorization for the collection and communication of personal information authorization for the collection and communication of personal information authorization for sources from which information may be collected include benefits comparation, only the information deemed accessary to manage my fife and setting my claims to; (a) collect from any person or legal entity, or from any public or parapulsic organization, only the information deemed accessary to manage my fife and setting my comparation, collected from any person or legal entity, or from any public or parapulsic organization, only the information deemed accessary to manage my fife and setting my comparation, collected from any person or legal entity, or from any public or parapulsic organization, only the information may be enabled any comparation of the collected from the benefits of prometric maphyses. No communicate to the said personal and also use the premount information in trans the map have about me in existing files that are now closed. Industrial in a final and also use the premount information in trans the natural have about an ensuing the submitted prometric maphyses. A photocopy of this authorize Designidars infanced Security Life Assurance Company, Disability claims. Employee's signature Date In the province in which employee is taxed. Amount of provincial exemption S Policy No. Q057 - Concordia University Date Claim Received by Insurer; North Day North	work? Yes \(\bar{\bar{\bar{\bar{\bar{\bar{\bar{	Jo 🗖	_	
Has or will a claim be filed for Workers' Compensation or Québec Auto Insurance If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association or through mother campleyer or under an individual policy, give the following particulars: Name of Insurer				
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Name of Insurer Policy No. Certificate No. Date Benefits Commence Benefit Period Benefit Amount Month Date Date	:			
Employee's signature Date Authorization for the collection and communication of personal information Inturbrize Despiration is Found to Security Life Assumance Company strictly for the purposes of determining my insurability, managing my file and setting my claims to (4) collect from any person or legal entity, or from any public or parapublic organization, only the information to manage my file and setting my claims to (4) collect from any person or legal entity, or from any public or parapublic organization, only the information thereal necessary to manage my file and setting my common speculations to (4) collect from any personal information officers or investigation agencies, the policyholder, my employer of former employers; (b) communicated information about me 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 information about me that is deterned necessary for the purposes of my file; (c) when necessary necessary in the purposes of my file; (c) when necessary requires an inquiry report about n and also use the personal information is may have about me in existing files that are now closed. I authorize Designations Financial Security Life Assurance Company, Disability about me in existing files that are now closed. I authorize Designations Financial Security Life Assurance Communication is as valid as the original request completed, and forward completed forms to Designatins Financial Security Life Assurance Company, Disability claims. Employee's signature Date Sin No. **ERYIMPORTANT: Please have the declaration of the attending physician-original request completed, and forward completed forms to Designatins Financial Security Life Assurance Company, Disability claims. **Employee's Stratement (**Received by Insurer**) Date Claim Received by Insurer* Teaching the provincial Authorization of the attending ph	e Benefits Commence	Renefit Period	Renefit Amoun	
COMMENTS: I hereby certify that the above answers are full and true to the best of my knowledge and belief. Employee's signature	223	20110110 T C110U	20.ioiit Ailiouii	
Employee's signature Date Employee's signature Date Authorization for the collection and communication of personal information authorize Designation 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 demend necessary to manage my file. The processor of 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 demend necessary to manage my file. The processor of facilities, the Medical Information Birurau, insurance companies, personal information officers or investigation agencies, the policyblodier, my employer of former employers, (c) communicate to the said persons or more exhaustreal 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. JERY 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 Auronator of federal exemption Average Weekly salary* Date contract started Month Day Year Month Day Year Month Day Year Month Day Year Last day paid by Meath Day Weekly salary Date contract to disability income benefits under any government legislation, including Workers' Compensation or Provincial Auto Insurance? Yes Note:				
Employee's signature Date Authorization for the collection and communication of personal information Lauthorize Designations 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 more companies, personal information officers or investigation agencies, the policyholder, my employer of former employers; (b) communicate to the said persons or reganizations only the personal information obtains the that is deemed necessary for the persons of information officers or investigation agencies, the policyholder, my employer of former employers; (b) communicate to the said persons or organizations only the personal information in timaly 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 Oction No. Q057 - Concordia University Tasching Average Control number Tasching Average Weekly salary* Average weekly salary = 108% of total contract value divided by total number of weeks in contract *Average weekly salary = 108% of total contract value divided by total number of weeks in contract *Average weekly salary = 108% of total contract value divided by total number of weeks in contract *Average weekly salary = 108% of total contract value divided by total number of weeks in contract *Average weekly salary = 108% of total contract value divided by total number of we	best of my knowledge	e and belief		
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Effective Date: September 2011