UV INSURANCE

GROUP INSURANCE

Disability Insurance Claim – Employee

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Important Notes

When an employee is absent from work and may be entitled to disability benefits, or qualify for waiver of premiums, please forward this form to the insurer as soon as possible. An initial claim must include a completed and signed employer's statement, employee's statement and attending physician's statement. For any long-term disability or waiver of premium claim, form **EN-5051A – Education, Training and Work Experience Questionnaire** is also required.

If you are not already using UV Insurance's Direct Deposit service, please complete form **EN-5025A – Direct Deposit of Benefits** and submit it with your claim. If your claim is approved, your benefits will be deposited directly into your bank account. When you enrol in direct deposit, you may continue to receive your benefit statements by mail. You will also receive your payment more quickly, avoiding postal delays and trips to the bank, provided your claim is approved and your policy allows for direct deposit.

Please note that continued eligibility for disability benefits and payment of those benefits are subject to payment of all premiums due, except in the case of persons insured who qualify for a waiver of premium. If these premiums cease to be paid, the applicable coverage and benefits will be discontinued in accordance with the provisions of the contract.

Section B – Employee Information

1. Group # _____ Division _____ Class _____ Certificate # _____
2. Last name _____ First name _____
3. Date of birth Y M D 4. Phone _____
5. Address _____
   City _____ Province _____ Country _____ Postal code _____
6. Email _____

Section C – Employee Statement

1. Cause of the disability _____
   a) Date of first medical consultation Y M D
   b) Name of hospital or clinic _____
   c) Attending physician's first name _____ Last name _____
   d) Family physician's first name _____ Last name _____
   e) Describe the circumstances that led to your sick leave:

2. Were you hospitalized? ☐ Yes ☐ No If **Yes**, during what period? From Y M D to Y M D
   Hospital name _____
3. Is your disability the result of an accident? ☐ Yes ☐ No If **Yes**, please specify:
   a) When did the accident occur? Date Y M D Time _____ ☐ AM ☐ PM
   b) Where did the accident occur? _____

Section C – Employee Statement (cont.)

4. Have you ever had the same condition or a similar illness or accident? ☐ Yes ☐ No If **Yes**, please specify:

   Reason _____ Date Y M D

   Physician's first name _____ Last name _____

5. Please explain why you are unable to perform your job duties:

Section D – Income

1. On what date do you expect to return to work? Y M D

2. Are you receiving disability benefits or income from any other insurance? ☐ Yes ☐ No If **Yes**, please specify:

Source	Since what date?
	Y M D
	Y M D
	Y M D

3. Have you submitted a claim for benefits?

Claim submitted to	Claim submitted		Date	Decision		Pending response
	Yes	No		Accepted	Refused	
Canada Pension Plan	☐	☐	Y M D	☐	☐	☐
Quebec pension plan (QPP)	☐	☐	Y M D	☐	☐	☐
Employment and Social Development Canada (ESDC)	☐	☐	Y M D	☐	☐	☐
Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)	☐	☐	Y M D	☐	☐	☐
Société de l'assurance automobile du Québec (SAAQ)	☐	☐	Y M D	☐	☐	☐
Indemnisation des victimes d'actes criminels (IVAC)	☐	☐	Y M D	☐	☐	☐
Any other organization or insurer	☐	☐	Y M D	☐	☐	☐

Please attach a copy of the documents relating to the acceptance or denial of your claim, as applicable.

Section E – Collection, Use and Disclosure of Personal Information

This form is for UV Insurance to obtain your valid consent (through your signature) to collect and disclose your personal information for the purpose of administering your current claim.* With your consent, UV Insurance may collect the necessary personal information regarding your health status, medical history and eligibility for benefits.

This information may be collected from any individual or legal entity, as well as from any public, parapublic or private organization, including, without limitation, any health care professional (in a hospital, medical clinic or paramedical clinic), any health care organization or institution, any public health insurance plan, any public pension plan, insurance companies, reinsurers, personal information agents or investigative agencies, the plan administrator and its representatives, the policyholder, and your current or former employers.

Please note that any personal information disclosed to UV Insurance beyond the scope of this request will not be collected or used.

* This authorization is only valid for the claim listed below.

Section F – Consent and Signature

By signing, you acknowledge that in the event any of your personal information is inaccurate, incomplete, or ambiguous, you may ask for it to be corrected by contacting UV Insurance. You also have the right to request information about how your personal information is used.

In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by contacting the UV Insurance Privacy Officer at the following address: 1990 rue Jean-Berchmans-Michaud, Drummondville, QC J2C 7G7.

For further details, please visit our website and consult our **Privacy Policy.**

By signing, the undersigned authorizes UV Assurance to disclose their personal information to the third parties listed on this form and to its reinsurers. This authorization is valid for any document predating signature of this authorization as well as any document produced within 90 days of the date of signature.

A photocopy or an electronic or scanned copy of this authorization has the same value as the original.

Signature

By signing below, the undersigned further confirms that they have read this form and agreed to it and acknowledges that a photocopy of this document has the same value as the original.

Address of signatory _____

City _____ Province _____ Postal code _____

Signed in _____ Date Y M D

X _____ _____

Signature | Signatory's name in block letters

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