Gouvernement du Québec
Ministère de la Santé et des Services sociaux

Programme Santé des Organisations et des Individus

SALARY INSURANCE CLAIM

SECTION A : Identification (to be completed by salaried employee)

LAST NAME : ____________ FIRST NAME : ____________ EMPLOYEE NO. : ____________

DATE OF BIRTH : __Y__ / __M__ / __D__ TELEPHONE NO. : (____) ____________ SIN : ____ - ____ - ____

DEPARTMENT : ____________ JOB TITLE : ____________ SHIFT : ____________

NAME OF IMMEDIATE SUPERIOR ____________ STATUS : FT ☐ PT ☐ TEMP ☐

NAME OF EMPLOYER ____________

AUTHORIZATION OF SALARIED EMPLOYEE

I declare that the above information is accurate and hereby authorize my healthcare professionals as well as authorized representatives of hospitals or clinics to release relevant information regarding my health condition, disability, or period of absence from work as described herein to my employer, my employer's commissioned representative, or my employer's salary insurance consulting department.

SIGNATURE : ____________ DATE : ____________

*Processing of request can be delayed if salaried employee does not give authorization.

GENERAL INFORMATION FOR CLAIMANT AND TREATING PHYSICIAN

DEFINITION OF DISABILITY

TO BE ELIGIBLE FOR SALARY INSURANCE BENEFITS, THE SALARIED EMPLOYEE MUST PROVE THAT HIS OR HER MEDICAL CONDITION MEETS ALL OF THE FOLLOWING CRITERIA:

1. THIS DISABILITY IS THE RESULT OF DISEASE, ACCIDENT, COMPLICATION OF PREGNANCY, OR CONDITION RELATING TO FAMILY PLANNING OR ORGAN OR BONE MARROW DONATION

AND

2. THE SALARIED EMPLOYEE IS RECEIVING MEDICAL ATTENTION FOR THIS DISABILITY

AND

3. THE SALARIED EMPLOYEE IS **TOTALLY UNABLE** TO ACCOMPLISH THE USUAL TASKS REQUIRED IN THE PERFORMANCE OF HIS OR HER DUTIES, OR OF ANY SIMILAR DUTIES OFFERED BY THE EMPLOYER AND INVOLVING EQUIVALENT COMPENSATION.

DISABILITY REHABILITATION OR PROGRESSIVE RETURN TO WORK

AFTER RECEIVING APPROVAL FROM THE APPROPRIATE AUTHORITY AND SUBJECT TO THE PROVISIONS IN COLLECTIVE AGREEMENTS, A SALARIED EMPLOYEE CAN QUALIFY FOR A REHABILITATION PERIOD WHILE CONTINUING TO BE SUBJECT TO THE SALARY INSURANCE PLAN.

PLEASE NOTE THAT THIS DOCUMENT IS SOLELY OF AN INFORMATIVE NATURE, AND THAT IT DOES NOT REPLACE OR IN ANY CASE ADD TO PROVISIONS IN COLLECTIVE AGREEMENTS IN EFFECT WITHIN THE PUBLIC OR PARAPUBLIC SECTORS.

SALARY INSURANCE CLAIM

Date of 1st consultation for this disability: Y / M / D

SECTION B: Medical report (to be completed by TREATING PHYSICIAN)

DIAGNOSIS

Principal: ______

Secondary: ______

CLASSIFICATION ACCORDING TO DSM-IV MULTIAXIAL SYSTEM

Axis I ______
(Clinical psychiatric disorders)

Axis II ______
(Personality disorders, substance or gambling addiction, alcoholism)

Axis III ______
(General medical conditions)

Axis IV ______
(Psychosocial and environmental problems, work problems)

Axis V ______
(Global assessment of functioning scale)

MEDICAL FOLLOW-UP

Was this person referred to a specialist? Yes ❒ Name and specialization: ______

Consultation results: ______

❒ **DIAGNOSTIC EXAMINATIONS** Specify: ______ Results: ______

❒ **HOSPITALIZATION** From: ______ To: ______

❒ **SURGERY** Specify: ______ Date: Y / M / D

❒ **PHYSIOTHERAPY / OCCUPATIONAL THERAPY** Starting date: ______ Frequency: ______

❒ **PSYCHOTHERAPY** Starting date: ______ Frequency: ______

❒ **MEDICATION** Specify: ______ Dosage: ______
______ Dosage: ______

❒ **OTHER** Specify: ______

PLAN FOR RETURN TO WORK

❒ Return to regular duties: Date: Y / M / D

❒ Progressive return to work in original position From: ______ To: ______

Hours or days per week: ______

❒ Temporary assignment (light duties) From: ______ To: ______

Hours or days per week: ______

Medical restrictions: ______

INTERRUPTION OF WORK

Specify medical reasons making salaried individual totally unable to fulfill his or her duties or other duties offered by employer:

______

Approximate duration of disability: Number of weeks: ______ Number of months: ______ Approximate date of return to work: Y / M / D

Is this incapacity to perform original duties permanent and total? Yes ❒ No ❒

Have you completed the following documents : RRQ ❒ Y / M / D SAAQ ❒ Y / M / D CSST ❒ Y / M / D IVAC ❒ Y / M / D

Date of next appointment: Y / M / D

PHYSICIAN INFORMATION

PHYSICIAN'S NAME (please print)	ADDRESS	LICENSE NUMBER
PHYSICIAN'S SIGNATURE (stamp not accepted)	TELEPHONE	Y / M / D DATE
SPECIALIZATION	FAX	