

Group No.

GPM User ID

INSTRUCTIONS

- FILL IN THE FORM.** If the disability benefits paid under the plan are taxable, the social insurance number must be provided for the preparation of tax forms.
- ATTACH THE REQUIRED CLAIMS.** In order to proceed with your claim GPM must receive the **Employer's claim statement** and the **Physician's claim statement**. (Obtaining the information provided in support of the present application is at your expense.)
- SIGN THE FORM.**

PARTICIPANT STATEMENT

Participant's Family Name(s)		Participant's Given Name(s)		Date of Birth (d/m/yyyy)
<input type="text"/>		<input type="text"/>		<input type="text"/>
Address (Civic No. and Street Name)			Apartment	
<input type="text"/>			<input type="text"/>	
City		Province	Postal Code	
<input type="text"/>		<input type="text"/>	<input type="text"/>	
Phone No.	Participant's Email Address		Gender	
<input type="text"/>	<input type="text"/>		<input type="radio"/> F <input type="radio"/> M	
Job Title			Social Insurance No.	
<input type="text"/>			<input type="text"/>	

About Your Illness or Injury

Last day of full time duties (d/m/yyyy)

Please describe your illness or injury and explain how it prevents you from working:

Please describe the symptoms preventing you from performing your duties at work:

Disability Due to an Accident

Is your disability due to an accident? No Yes » Please indicate: **DATE** (d/m/y) **TIME** **LOCATION**

Benefits and Other Sources of Income

Please indicate any amount of money that you are currently receiving or expect to receive from the following sources. This information may be considered during the review of your claim.

Source	Amount (\$)	Frequency of payment	Source	Amount (\$)	Frequency of payment
Any Other Disability Insurance <input type="radio"/> Yes:	<input type="text"/>		Canada and/or Quebec Pension Plan <input type="radio"/> Yes:	<input type="text"/>	
CNESST <input type="radio"/> Yes:	<input type="text"/>		IVAC <input type="radio"/> Yes:	<input type="text"/>	
Employment Insurance <input type="radio"/> Yes:	<input type="text"/>		Any other income <input type="radio"/> Yes:	<input type="text"/>	
S.A.A.Q. <input type="radio"/> Yes:	<input type="text"/>				

DECLARATION AND AUTHORIZATION

By submitting your claim, you confirm that the information provided is accurate, precise and true. Any false information may result in the rejection of your claim. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry. I authorize GPM to use my social insurance number. I authorize any person or entity that has relevant personal information about me, including my employer, health professionals, my doctor, medical institutions, insurers, and persons performing services on behalf of GPM to disclose the information necessary to the activities of pricing, management and payment of claims. I authorize GPM to convey to my long-term disability insurance company any information about my absence to ensure the transition of my application to my long-term disability plan. I agree that I am responsible to keep the original documents relating to my claim for short-term disability. I agree that a photocopy of this authorization is as valid as the original.

PARTICIPANT'S SIGNATURE Date (d/m/yyyy)