MÉDIC construction

APPLICATION FOR SHORT-TERM SALARY INSURANCE BENEFITS
How to make a claim

11A-B

The Regulation Respecting Complementary Social Benefits Plans in the Construction Industry provides for salary insurance coverage in the case of total disability (under certain conditions). Here is how to apply for short-term salary insurance benefits (11A-B).

EMPLOYMENT INSURANCE STATEMENT

11A

The public Employment Insurance plan administered by Human Resources and Skills Development Canada (HRSDC) is the first payer in case of disability. It is therefore necessary that you make an Employment Insurance claim for sickness benefits (even if you are not eligible for these benefits). In addition, in some situations, an individual may be eligible for two consecutive Employment Insurance sickness benefits claims.

To process your salary insurance application, we have to know whether you are eligible for Employment Insurance sickness benefits, whether it is for one or two claims.

According to the Department of Human Resources and Skills Development Act (SC 2005, c 34) and the Privacy Act (R.S.C., 1985, c. P-21.), your consent is necessary to authorize HRSDC to transmit the Employment Insurance Statement and all information related to it to the Commission de la construction du Québec (hereinafter the "Commission").

However, if you are an employer not covered by the Employment Insurance Act, you do not have to make an Employment Insurance claim. Please write "not covered" on the form "Employment Insurance Statement (11A)" and return it to the Commission with your form "Statement of Worker and of Attending Physician (11B)."

How to proceed

1. **Online claim:**

   Make an Employment Insurance claim online at ***servicecanada.gc.ca***. If you do not have Internet access, you can go to a Service Canada Centre and use one of the workstations there.

2. Fill out, sign, and date sections A and B of the enclosed form "Employment Insurance Statement (11A)."

3. Mail the form "Employment Insurance Statement (11A)" to the following address: Service Canada, P.O. Box 60, Boucherville (Québec), J4B 5E6. You can also take it in person to a Service Canada Centre.

4. Service Canada will return directly form 11A, duly filled out, to the Commission when your Employment Insurance claim is processed.

For more information, contact Customer Services in your region or call the toll-free number 1 888-842-8282 or visit our Web site, *ccq.org*, under the "MÉDIC Construction" tab. You can also consult the pamphlet "Salary insurance, hour credits and insurance prolongation".

THE FORM "EMPLOYMENT INSURANCE STATEMENT (11A)" WILL BE RETURNED TO US BY SERVICE CANADA AT THE FOLLOWING ADDRESS:

Commission de la construction du Québec

DIRECTION DES AVANTAGES SOCIAUX
SECTION ASSURANCE INVALIDITÉ
CASE POSTALE 2515
SUCCURSALE YOUVILLE
MONTRÉAL (QUÉBEC)
H2P 0A7

See over

MÉDIC construction

APPLICATION FOR SHORT-TERM SALARY INSURANCE BENEFITS
How to make a claim

11A-B

EMPLOYEE'S STATEMENT 11B

Answer all the questions in "Employee's Statement (11B)." If any information is missing, it may delay processing of your salary insurance application. Here are some important aspects not to forget:

Section 2 – Information regarding employment - Write in the last day that you were at work.

Section 3 – Information regarding the disability - If your disability is the result of **an accident**, clearly indicate the circumstances (work-related accident, motor vehicle accident, or other), the date and time, and the location, and give a detailed description of the event.

Section 4 - Other income: Tick **"yes" or no" to each question** and, if applicable, enclose a copy of any decision, acceptance notice, or first notice of payment that you have received from these agencies.

Section 5 - Employee's authorization – Sign and date the form. You thus certify the accuracy of the information supplied and allow us to obtain the supplementary information needed to analyze your application for salary insurance benefits.

ATTENDING PHYSICIAN'S STATEMENT

Do not answer any questions in the "Attending physician's statement (11B)." It must be filled out, signed, and dated **by a physician** who is a member of the Collège des médecins du Québec (or analogous corporation in another province or country). If you have insurance, the cost incurred to have this form filled out is partly reimbursable. Staple your original receipt to form 11B.

HOUR CREDITS

You don't have to fill out the form "Application for hour credits (15)" in addition to your "Short-term disability benefits claim form (11A-B)." If your salary insurance application is accepted, hour credits will be granted to you (under certain conditions).

SENDING YOUR APPLICATION

Service Canada will return the "Employment Insurance Statement (11A)," duly completed, directly to the Commission when your Employment Insurance claim is processed.

Send the "Employee's Statement and Attending Physician's Statement (11B)," duly filled out and signed, as soon as possible, in the enclosed response envelope or to the address given below.

You cannot claim salary insurance benefits for a period of more than 30 days before the date on which you submit your application.

Your application must be sent to the Commission at most 12 months after your disability began or it will be rejected.

We can process your salary insurance application only if you have supplied all the information required for the processing of your application.

If more supporting documentation is required, it will be requested by an authorized person from the Commission.

For more information, contact the Customer Services in your region or call the toll-free number 1 888-842-8282 or visit our Web site, *ccq.org*, under the "MÉDIC Construction" tab. You can also consult the pamphlet "Salary insurance, hour credits and insurance prolongation".

PLEASE RETURN THE FORM "EMPLOYEE'S STATEMENT AND ATTENDING PHYSICIAN'S STATEMENT (11B)" TO THE FOLLOWING ADDRESS:

Commission de la construction du Québec

DIRECTION DES AVANTAGES SOCIAUX
SECTION ASSURANCE INVALIDITÉ
CASE POSTALE 2515
SUCCURSALE YOUVILLE
MONTRÉAL (QUÉBEC)
H2P 0A7

MÉDIC construction

EMPLOYMENT INSURANCE STATEMENT
APPLICATION FOR SHORT-TERM SALARY INSURANCE BENEFITS

11A

SECTION A – IDENTIFICATION OF EMPLOYEE (to be filled out by the employee)

LAST NAME | FIRST NAME | SOCIAL INSURANCE NO.

NUMBER AND STREET | APT. NO. | CITY OR TOWN, PROVINCE

POSTAL CODE | TELEPHONE NO. (RESIDENCE) Area Code | TELEPHONE NO. (OTHER) Area Code | DATE OF BIRTH Day Month Year

SECTION B – EMPLOYEE'S AUTHORIZATION (to be filled out and signed by the employee)

IMPORTANT

I, the undersigned,_____, authorize Human Resources and Skills Development Canada (HRSDC) to transmit this statement and all information related to it to the Commission de la construction du Québec (CCQ). The present authorization will be valid for as long as it takes for my application for salary insurance benefits and hour credits to be analyzed.

The information transmitted will be used only to process the present application and will be accessible only to employees who must use this information for the discharge of their duties.

EMPLOYEE'S SIGNATURE

DATE Day Month Year

SECTIONS C TO I MUST BE COMPLETED BY AN AUTHORIZED EMPLOYMENT INSURANCE AGENT

How to complete the form:
When the claim has been filed AND processed, complete the appropriate sections in the claimant's file:

Sections C et I	Always complete
Section D	Complete if an initial claim for sickness benefits has been filed for the present incapacity
Section E	Complete if a claim has been renewed or converted into sickness benefits for the present incapacity
Section F	Complete if a subsequent claim has been filed for the present incapacity. If this is the case, you must also complete sections D and E
Section G	Complete if the employee is eligible for an initial, renewed, or continuing claim for sickness benefits

SECTION C – INFORMATION RELATED TO A CLAIM

1. Is the claimant making a claim for sickness benefits? ☐ YES ☐ NO

2. If no, has the claimant claimed benefits (regular or sickness) over the last 52 weeks? ☐ YES ☐ NO

If the claimant is claiming or has claimed sickness benefits, complete question 3 and the appropriate sections.

If not, skip to section I, "Certification of an authorized Employment Insurance agent"

3. Was the claim made late? ☐ YES ☐ NO

If yes, was an antedated claim made? ☐ YES ☐ NO ➡ ☐ Accepted ☐ Rejected

SECTION D – INITIAL CLAIM

4. Is the claimant eligible for an initial claim for sickness benefits? ☐ YES ☐ NO

If yes, what is the date of commencement of benefits? Day Month Year

If no, please give the reasons:_____

☐ Tick here if a greater number of hours of insurable employment are required for eligibility

If the claimant is not eligible, skip to section I, "Certification of an authorized Employment Insurance agent"

5. Waiting period Week 1: Day Month Year Week 2: Day Month Year

6. Was the waiting period cancelled because of a sick leave paid by the employer? ☐ YES ☐ NO

7. Please give the details of sickness benefits paid to date:

Day Month Year AU Day Month Year Day Month Year AU Day Month Year

If sickness benefits have not been paid or if benefits have been suspended, please give us the reasons in ***section G, "Suspension of sickness benefits"***

8. Is the claim terminated? ☐ YES ☐ NO

See over

LAST NAME	FIRST NAME	SOCIAL INSURANCE NO.

SECTION E – RENEWED OR CONTINUING CLAIM

9. What is the date that the claim was renewed or converted into a sickness benefits claim? Day Month Year

10. Was the claimant receiving regular benefits in the week preceding the renewal or conversion? ☐ YES ☐ NO

11. Is the claimant eligible for a maximum of 15 weeks of sickness benefits? ☐ YES ☐ NO

If no, give the maximum number of weeks of sickness benefits eligibility:
(Example: Eligible for 13 weeks maximum on the renewed claim)

12. What is the commencement date for this benefit period? Day Month Year

13. Waiting period (Please complete even if it was served before the renewal or conversion)

Week 1: Day Month Year Week 2: Day Month Year

14. Please give the details of the sickness benefits paid since the date of renewal or conversion.

Day Month Year TO Day Month Year Day Month Year TO Day Month Year

If sickness benefits have not been paid or have been suspended, please give us the reasons in ***section G, "Suspension of sickness benefits"***

15. Is the claim terminated? ☐ YES ☐ NO

▶ ***If yes, go to section F, "Subsequent claim"***
If no, skip to section G, "Suspension of sickness benefits"

SECTION F – SUBSEQUENT CLAIM

16. Is the claimant claiming sickness benefits in a subsequent claim? ☐ YES ☐ NO

▶ ***If yes, complete sections D "Initial claim" and E "Renewed or continuing claim"***
If no, go to section G, "Suspension of sickness benefits"

SECTION G – SUSPENSION OF SICKNESS BENEFITS

IMPORTANT

17. Has there been a suspension of benefits since the commencement of the benefit period for the initial sickness benefits claim OR since the date of the claim renewal or conversion to sickness benefits? ☐ YES ☐ NO

18. If yes, for which period? Day Month Year TO Day Month Year

19. If sickness benefits have not been paid or if there has been a suspension, please give us the reasons:

_____

_____

Go to section I, "Certification of an authorized Employment Insurance agent"

SECTION H – REMARKS

_____

_____

SECTION I – CERTIFICATION OF AN AUTHORIZED EMPLOYMENT INSURANCE AGENT

NAME (PLEASE PRINT)	SIGNATURE OF AN AUTHORIZED EMPLOYMENT INSURANCE AGENT	Day Month Year

PLEASE RETURN THE FORM "EMPLOYMENT INSURANCE STATEMENT (11A)" TO THE FOLLOWING ADDRESS:

Commission de la construction du Québec

DIRECTION DES AVANTAGES SOCIAUX
SECTION ASSURANCE INVALIDITÉ
CASE POSTALE 2515
SUCCURSALE YOUVILLE
MONTRÉAL (QUÉBEC)
H2P 0A7

MÉDIC construction

EMPLOYEE'S STATEMENT
APPLICATION FOR SHORT-TERM SALARY INSURANCE BENEFITS

11B

IMPORTANT PLEASE WRITE CLEARLY AND SEND US THE ORIGINAL COPY OF YOUR REQUEST. WE WILL PROCESS THIS REQUEST FOR DISABILITY INCOME BENEFITS ONLY IF CORRECT ANSWERS HAVE BEEN PROVIDED TO ALL QUESTIONS ON THIS FORM.

1 IDENTIFICATION OF EMPLOYEE

(Please write in block letters)

LAST NAME

FIRST NAME

NUMBER AND STREET, APT NO.

CITY OR TOWN

PROVINCE

POSTAL CODE

PERMANENT ADDRESS ☐

TEMPORARY ADDRESS ☐

SOCIAL INSURANCE NUMBER

DATE OF BIRTH (Year Month Day)

TELEPHONE NUMBER OF INSURED (Area Code)

2 INFORMATION CONCERNING EMPLOYMENT

NAME OF LAST EMPLOYER

TELEPHONE No. OF EMPLOYER (Area Code)

YOUR TRADE OF OCCUPATION

LAST DAY WORKED (Year Month Day)

3 INFORMATION CONCERNING DISABILITY

1- FIRST DAY OF DISABILITY: (Year Month Day)

2- HAVE YOU RECOVERED? YES ☐ NO ☐

IF YES, ON WHAT DATE? (Year Month Day)

3- HAVE YOU RETURNED TO WORK OR ARE YOU AVAILABLE TO WORK? YES ☐ NO ☐

IF NOT, APPROXIMATE DATE OF YOUR RETURN OR YOUR AVAILABILITY TO WORK: (Year Month Day)

4- DOES THIS CLAIM CONCERN AN ACCIDENT? YES ☐ NO ☐ SI YES, SPECIFY: WORKING ACCIDENT ☐ MOTOR VÉHICLE ☐ OTHER TYPE OF ACCIENT ☐

DETAILS ON ACCIDENT: DATE OF ACCIDENT: (Year Month Day) AT ____ O'CLOCK AM ☐ PM ☐

PLACE OF ACCIDENT: _____

CIRCUMSTANCES: _____

(If necessary, please use an extra sheet of paper) _____

NAMES OF WITHNESSES: _____ (Area Code Telephone No.)

5- WERE YOU HOSPITALIZED? YES ☐ NO ☐

IF YES, NAME OF ESTABLISHMENT: _____

ADMITTED ON : (Year Month Day) AT ____ O'CLOCK AM ☐ PM ☐

DISCHARGED ON: (Year Month Day) AT ____ O'CLOCK AM ☐ PM ☐

4 OTHER REVENUES

DO YOU RECEIVE / OR HAVE YOU APPLIED FOR / OR DO YOU INTEND TO APPLIED FOR / DISABILITY OR PENSION BENEFITS FROM:

COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐
SOCIÉTÉ DE L'ASSURANCE-AUTOMOBILE DU QUÉBEC?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐
RÉGIE DES RENTES DU QUÉBEC?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐
CANADA PENSION PLAN?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐
CONSTRUCTION INDUSTRY'S PENSION PLAN?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐
OTHER INDIVIDUAL OR COLLECTIVE SALARY INSURANCE PLAN?	NO	YES	AMOUNT	$	WKLY ☐	MTHLY ☐	TO STUDY ☐

PLEASE SEND US A COPY OF THE DECISION AND THE NOTICE OF FIRST PAYMENT YOU HAVE RECEIVED FROM THE ABOVE MENTIONED ORGANISMS.

PROVINCIAL INCOME TAX MUST BE DEDUCTED FROM YOUR DISABILITY INCOME BENEFITS.
FEDERAL TAX DEDUCTIONS ARE NOT COMPULSORY BUT CAN BE MADE AT SOURCE, IF YOU WISH.

SHOULD FEDERAL TAX BE DEDUCTED AT SOURCE? YES ☐ NO ☐

5 EMPLOYEE AUTORIZATION

I CERTIFY THAT ALL INFORMATION PROVIDED IN SUPORT OF MY REQUEST FOR DISABILITY INCOME BENEFITS IS ACCURATE.

I HEREBY AUTHORIZE ANY PERSON OR LEGAL ENTITY DISPENSING MEDICAL SERVICE (PHYSICIANS, HOSPITALS), AS WELL AS INSURANCE COMPANIES, INVESTIGATION BUREAU, EMPLOYERS, THE BUREAU DE RENSEIGNEMENTS MÉDICAUX, THE COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL DU QUÉBEC, THE RÉGIE DE L'ASSURANCE-MALADIE DU QUÉBEC, THE SOCIÉTÉ DE L'ASSURANCE-AUTOMOBILE DU QUÉBEC, HUMAN RESOURCES AND SKILLS DEVELOPMENT CANADA (HRSDC) AND THE RÉGIE DES RENTES DU QUÉBEC TO SUPPLY THE COMMISSION DE LA CONSTRUCTION DU QUÉBEC (CCQ) OR ITS AUTHORIZED REPRESENTATIVES ANY INFORMATION RELATING TO ME.

THE INFORMATION GIVEN TO THE COMMISSION DE LA CONSTRUCTION DU QUÉBEC (CCQ) MUST ONLY BE USED TO STUDY MY CLAIM AS PROVIDED IN THE REGULATION RESPECTING COMPLEMENTARY SOCIAL BENEFITS PLANS IN THE CONSTRUCTION INDUSTRY. HOWEVER, THIS INFORMATION MAY BE REVEAL TO ANY PERSON OR LEGAL ENTITY INVOLVED IN STUDYING MY APPLICATION OR ANY OTHER PERSONS IF REQUIRED BY LAW OR IF I EXPRESSLY AUTHORIZE IT.
THIS AUTHORIZATION OR A COPY OF IT SHALL REMAIN VALID AS LONG AS MY CLAIM IS UNDER STUDY.

SIGNATURE OF EMPLOYEE (REQUIRED)

DATE (Year Month Day)

IMPORTANT

SEND YOUR STATEMENT AS SOON AS POSSIBLE TO:

Commission de la construction du Québec

DIRECTION DES AVANTAGES SOCIAUX
SECTION ASSURANCE INVALIDITÉ
CASE POSTALE 2515
SUCCURSALE YOUVILLE
MONTRÉAL (QUÉBEC)
H2P 0A7

MÉDIC construction

ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT PLEASE ANSWER ALL QUESTIONS IN BLOCK LETTERS. THIS STATEMENT MUST BE COMPLETED BY A MEMBER OF THE PROFESSIONAL CORPORATION OF PHYSICIANS.

11B

1 IDENTIFICATION OF PATIENT

LAST NAME _____ FIRST NAME _____ AGE _____

OCCUPATION _____

2 CIRCUMSTANCES

TO YOUR KNOWLEDGE, IS THE DISORDER DUE TO:

A WORKING ACCIDENT ☐ AN OCCUPATIONAL DISEASE ☐ A MOTOR VEHICLE ACCIDENT ☐

OTHER TYPE OF ACCIDENT ☐ OTHER DISEASE ☐

3 DIAGNOSIS

DIAGNOSIS OF CURRENT DISABILITY

A- PRIMARY: _____

B- SECONDARY: _____

C- SUBJECTIVE SYMPTOMS: _____

D- OBJECTIVE SIGNS (INCLUDING RECENT X-RAYS, ECG OR OTHER TEST RESULTS): _____

E- TO YOUR KNOWLEDGE:

1- WHEN DID THE SYMPTOMS APPREAR OR THE ACCIDENT OCCUR? _____ (Year Month Day)

2- HAS THE PATIENT SUFFERED FROM THIS TYPE OF DISORDER PREVIOUSLY? YES ☐ NO ☐ IF YES, DATE AND DETAILS: _____ (Year Month Day)

_____

4 REFERENCES

A- WAS THIS PERSON REFERRED TO YOU BY ANOTHER PHYSICIAN? YES ☐ NO ☐ IF YES, ON WHAT DATE? _____ (Year Month Day)

B- NAME OF PHYSICIAN: _____

5 APPOINTMENTS

A- DATE OF FIRST VISIT FOR THE CURRENT DISABILITY: _____ (Year Month Day)

B- DATE OF LAST VISIT: _____ (Year Month Day)

C- DATE OF NEXT VISIT: _____ (Year Month Day)

D- HAVE YOU BEEN TREATING THIS PATIENT SINCE THE CURRENT DISABILITY BEGAN? YES ☐ NO ☐

E- FREQUENCY OF VISITS: WEEKLY ☐ MONTHLY ☐

OTHER ☐ SPECIFY: _____

6 TREATMENT

A- NATURE OF TREATMENTS: _____

B- PRESCRIBED MEDICATION AND DOSAGE: _____

C- DATE OF HOSPITALIZATION: _____ (Year Month Day) D- DATE OF DISCHARGE: _____ (Year Month Day)

E- REASON FOR HOSPITALIZATION (TEST, TREATMENT, SURGURY) SPECIFY: _____

F- DATE OF SURGERY: _____ (Year Month Day) G- IF THE DISORDER IS THE RESULT OF PREGNANCY, WHAT IS THE EXPECTED DATE OF DELIVERY? _____ (Year Month Day)

H- HAVE YOU REFERRED THE PATIENT TO ANOTHER PHYSICIAN? YES ☐ NO ☐ IF YES, DATE: _____ (Year Month Day) VISITING DATES: _____

NAME OF PHYSICIAN AND SPECIALITY: _____

7 INCAPACITY

A- THIS PATIENT WAS TOTALLY DISABLED (UNABLE TO EXERCISE HIS / HER PROFESSION) FROM: _____ (Year Month Day) TO: _____ (Year Month Day)

B- IF PATIENT IS STILL INVALID, WHEN CAN HE / SHE RETURN TO HIS / HER PROFESSION? _____ (Year Month Day)

C- IF THE DATE CANNOT BE DETERMINED, ESTIMATE NUMBER OF ADITIONAL WEEKS REQUIRE BEFORE HE / SHE MAY RETURN TO HIS / HER PROFESSION: _____

D- HOW LONG DID OR WILL THE PATIENT'S PARTIAL DISABILITY LAST (ABILITY TO EXERCISE HIS / HER PROFESSION PART TIME)? _____ (Year Month Day)

E- HOW DOES THE PATIENT'S DISORDER AFFECT HIS / HER ABILITY TO WORK? _____

_____

REMARKS: _____

_____

8 IDENTIFICATION OF PHYSICIAN

NAME OF PHYSICIAN _____ ADDRESS _____

Area code Telephone No.

GENERAL PRACTIONER ☐ SPECIALIST ☐ SPECIFY: _____

Postal code

SIGNATURE OF PHYSICIAN _____ (Year Month Day)

Permit No.