COMMISSION DE LA CONSTRUCTION DU QUÉBEC

# REQUEST FOR BENEFITS REDUCED LIFE EXPECTANCY OR RETIREMENT FOR DISABILITY

## EMPLOYEE'S DECLARATION



## 1. EMPLOYEE'S IDENTIFICATION

| CCQ client number or social insurance number | Telephone number |
|---|---|
| Last name | First name |

| No. | Street | Apartment no. |
|---|---|---|

| City | Province | Postal code |
|---|---|---|

## 2. EMPLOYMENT-RELATED INFORMATION (UNLESS REQUEST FOR REDUCED LIFE EXPECTANCY)

| Are you currently working? ☐ Yes ☐ No | Name of your last employer | Employer's telephone number |
|---|---|---|

| Your trade or occupation | Date of last day of work (YYYY-MM-DD) |
|---|---|

Please list and detail each task performed and give the percentage (%) of time devoted to each.

## 3. INFORMATION RELATED TO THE DISABILITY

| First day of disability (YYYY-MM-DD) | Has your disability ended? ☐ Yes ☐ No | If yes, on which date? (YYYY-MM-DD) |
|---|---|---|

Explain the reasons for which your disability currently keeps you from working.

## 4. OTHER ORGANIZATIONS

Are you receiving disability benefits or have you applied to:

| **Please answer each question** | | Request accepted | Request denied | Request under study |
|---|---|---|---|---|
| Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) | ☐ Yes ☐ No | ☐ | ☐ | ☐ |
| Société de l'assurance automobile du Québec (SAAQ) | ☐ Yes ☐ No | ☐ | ☐ | ☐ |
| Retraite Québec | ☐ Yes ☐ No | ☐ | ☐ | ☐ |
| Other individual or group salary insurance plan | ☐ Yes ☐ No | ☐ | ☐ | ☐ |

**IMPORTANT**
Please attach a copy of the decision or notice of acceptance from these organizations, if applicable.



This document is available in adapted media upon request.

## 5. EMPLOYEE'S AUTHORIZATION

I declare that all information given in support to my application for benefits for reduced life expectancy or for benefits for reitrement for disability is accurate.

I authorize all physical or moral persons providing medical services (physicians, hospitals), as well as insurance companies, employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Société de l'assurance automobile du Québec, and Retraite Québec to transmit to the Commission de la construction du Québec (CCQ) or its representatives all information that they possess about me.

The information transmitted to the CCQ must be used solely for the analysis of my application for benefits in compliance with the provisions of the Règlement sur les régimes complémentaires d'avantages sociaux dans l'industrie de la construction. However, this information may be divulged to any physical or moral person participating in the analysis of this application or to all other persons if the law requires or if I expressly so authorize. The present authorization or a copy of it will be valid for as long as the analysis of my application lasts.

Employee's signature (obligatory) Date (YYYY-MM-DD)

**Please send this form and the supporting documentation to the following address below.**

Commission de la construction du Québec
Section Retraite et assurance vie
Case postale 2500, succursale Chabanel
Montréal (Québec) H2N 0A9

COMMISSION DE LA CONSTRUCTION DU QUÉBEC

# REQUEST FOR BENEFITS REDUCED LIFE EXPECTANCY OR RETIREMENT FOR DISABILITY

## DECLARATION OF ATTENDING PHYSICIAN

23

## 1. PATIENT'S IDENTIFICATION (TO BE FILLED OUT BY THE PHYSICIAN IN BLOCK LETTERS)

| Last name | First name | Date of birth (YYYY-MM-DD) |
|---|---|---|
| | | |

## 2. DIAGNOSIS

**Diagnosis of current disability**

| a) Primary | b) Secondary |
|---|---|
| c) Subjective symptoms | d) Objective signs (including results of recent radiography, EKG, or other tests) |

## 3. REFERRAL

Was the person referred to you by another physician? ☐ Yes ☐ No

If yes, on what date? (YYYY-MM-DD)

Name and specialty of referring physician

## 4. TREATMENT

| Nature of treatments | Medication prescribed and dosage |
|---|---|
| Response to treatment | Prognosis |

Description of surgery (if applicable)

Date of surgery (YYYY-MM-DD)

Did you refer the patient to another physician? ☐ Yes ☐ No

If yes, date referred (YYYY-MM-DD)

Physician's name and specialty

## 5. INCAPACITY

On what date did this person become totally disabled (incapable of performing the usual tasks of his or her position)? (YYYY-MM-DD)

When could he or she return to work? ☐ Never ☐ Undetermined or ☐ Date (YYYY-MM-DD) : ____________________

Are there functional limitations? ☐ Yes ☐ No

If yes ☐ Permanent ☐ Temporary

Please describe them

## 6. REDUCED LIFE EXPECTANCY

Does this person's medical condition reduce his or her life expectancy? ☐ Yes ☐ No

**IMPORTANT** If YES, do you estimate his or her life expectancy at ☐ Less than 2 years ☐ 2 years or more

Reason for your response

## 7. PHYSICIAN'S IDENTIFICATION

| Name of physician | Address |
|---|---|
| | |

☐ General practitioner ☐ Specialist Specify: ______________________________

| Permit no. | Telephone no. |
|---|---|
| Date (YYYY-MM-DD) | Fax no. |

Signature of physician