



beneva

Guide for employees newly on disability leave

FNEEQ Contract 001008-001010
Short-term and Long-term disability insurance

Prepared in collaboration with Beneva – July 2026

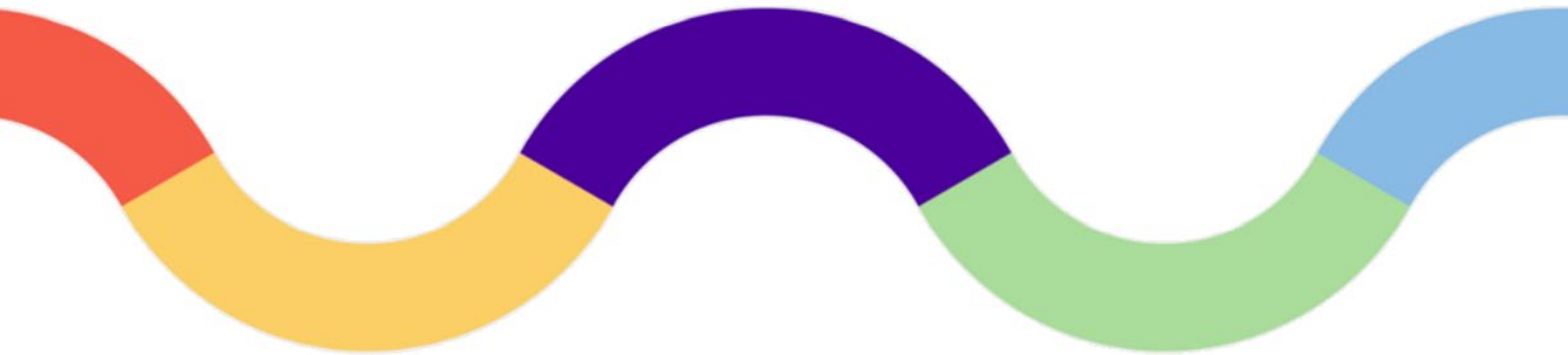


Table of Contents

1.	When should I submit my claim to the Insurer?.....	4
2.	How do I submit a claim for disability benefits to the Insurer?	5
3.	On what basis is my claim reviewed?	6
4.	How will I be notified of the decision?	8
5.	Can the Insurer offer me rehabilitation services?	8
6.	How does the return-to-work process work?	8
7.	Frequently Asked Questions	9

To assist individuals newly disabled through the process, the FNEEQ, in collaboration with Beneva, has prepared this guide for them and for the union advisors at local unions who support them.

Context

If you are no longer able to work as a teacher due to an illness or accident, it is reassuring to know that your disability insurance will help you get through this period. It replaces most of your income, allowing you to continue meeting your financial obligations while focusing on your recovery.

Depending on the terms of your collective agreement, short-term disability benefits may be paid by your employer or by Beneva.

In both cases, these benefits cover most of the income lost due to your temporary inability to work during the first 104 weeks of your disability.

Here is a summary of the provisions for short-term disability insurance:

Short-term disability insurance	Short-term disability benefits paid by <u>the employer</u>	Short-term disability insurance paid by <u>Beneva</u>
Elimination period	As per the collective agreement	Varies by institution: LaSalle College: 25 days Université Laval: 180 days Collège Trinité: 14 days Collège Universel 14 days ITHQ: 52 weeks ITAQ: 52 weeks Other institutions: 30 days
Maximum benefit period	24 months	24 months
Benefit amount	As per the collective agreement	75% of net salary
Indexation	As per the collective agreement	Based on the QPP Maximum 3%
Taxation	As per the collective agreement	Non-taxable

When the leave of absence exceeds 24 months (104 weeks), the group insurance policy issued by Beneva to the Fédération nationale des enseignantes et des enseignants du Québec (FNEEQ) provides for the payment of benefits to all eligible members. This long-term disability insurance ensures financial security for individuals as long as they meet the definition of disability.

Here is a summary of the provisions for long-term disability insurance:

Long-Term Disability Insurance	
Elimination Period	104 weeks plus sick days
Maximum benefit period	Up to age 65
Benefit amount	75% of net salary
Indexation	Based on the QPP Maximum 6%
Taxation	Non-taxable

You can review the details of these benefits in the Schedule of coverage or in the group insurance contract available on the [Beneva website](#) as well as on the FNEEQ website.

1. When should I submit my claim to the Insurer?

If your short-term disability insurance is paid by Beneva, submit your claim **as soon as possible**. This is recommended if your absence from work is likely to exceed the elimination period specified in your coverage.

Regarding long-term disability, it is recommended to begin the process of filing your claim starting in the **90th or 91st week of disability**, which is approximately **three months** before the end of the 104-week elimination period. This ensures that you submit your complete application at least one month before reaching the 104th week, thereby avoiding any interruption in your benefits.

2. How do I submit a claim for disability benefits to the Insurer?

Your claim must include the following documents:

Short-term disability insurance

- The following sections of the **Initial Claim Form – Claim for short- and long-term disability insurance benefits (P123)**:
 - *Insured person's declaration* to be completed by the member
 - *Medical Statement* to be completed by your doctor. Beneva also accepts the universal Initial Disability Insurance Medical Statement form issued by certain doctors in lieu of its own form.
- Copy of your most recent statement of participation in your pension plan (e.g., *RREGOP*)
- Sample check from the bank account to be used for benefit deposits

If you haven't already done so, create your Client centre account on the Beneva website: [Client centre - Log In | Beneva](#). The application claim form can be found there under the *Documents* tab in the *Form* section.

The Insurer will contact your employer directly to obtain the Employer's declaration and the documents required for your file, including copies of any medical records in their possession and your job description.

Long-term disability insurance

If you do not already have a short-term disability insurance file with Beneva, it is your responsibility to provide, in addition to the documents listed above, the required documents for the review of your long-term disability insurance claim. This includes your complete medical file, including progress notes from all physicians consulted since the start of your disability, as well as copies of specialist consultation reports, test and examination results, and expert assessment reports, if applicable (fees may be associated with this request).

The documents required to review your claim can be submitted via one of the following methods:

- **Via the Beneva Client centre**, under the *Disability* section, by clicking on "*Submit a Claim for disability benefits*" (confidential submission method) – recommended
- **By email to the following address:** prest.inv@beneva.ca (unsecured transmission method)
- **By fax** to 418-641-4321 or toll-free to 1-855-669-8830
- **By mail:** Beneva Inc.
P.O. Box 11051, Sainte-Foy Station, Quebec City (QC) G1V 0K1

3. On what basis is my claim reviewed?

The review of your claim begins once all the necessary information has been received. To determine your eligibility for short-term or long-term disability benefits, all of the following factors are considered:

1. The definition of disability in the FNEEQ contract, which reads as follows:

A state of incapacity, resulting from an illness, accident or surgical procedure directly related to family planning that requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment.

Medical care is not required if the disability is the result of loss of limbs or loss of sight and such loss can be definitively established to the Insurer's satisfaction.

2. Your medical condition, including ongoing treatments, limitations, and restrictions, etc.

3. Your job description as established by your employer

4. If you are receiving disability benefits from a government agency (e.g., CNESST, SAAQ, Retraite Québec, etc.), benefit coordination is provided for in the contract.

5. Information gathered during the initial phone interview

To fully understand your situation, the person responsible for your case will call you. This is the client relation specialist, who wants to get an overview before proceeding with the review. During this call, they will also explain the next steps in the process. Feel free to ask them any questions you may have! They are there to support you throughout the process.

The purpose of this call is to gain a clear understanding of your situation so we can ensure proper follow-up on your file and provide the support you need in your recovery.

The interview often helps clarify aspects of your limitations that aren't always included in medical reports.

Here are some examples of questions you may be asked as part of the review of your case:

Medical history

- What is the diagnosis? Is this the first time you have had this health issue?
- When is your next medical appointment?
- Is the disability related to an accident or an event? Can you provide details regarding the circumstances, date, and location, and specify whether this is a CNESST, IVAC, or SAAQ case?

Treatments

- Are you seeing a medical specialist? If so, what is their name and specialty?
- Are you seeing another healthcare professional (e.g., physiotherapist, occupational therapist, social worker, psychologist)? If so, what is their name and specialty?
- Are you taking any medication? If so, can you tell me the name and dosage?

Functional limitations

- In your daily life, are there any tasks or activities that you have stopped doing because of your health condition?
- If you compare your current abilities to those you had at the start of your leave of absence, are there any tasks or activities you have resumed?
- What was the ratio of good days to bad days over the past week? What makes a good day for you?

Job Requirements

- What is currently preventing you from performing your job?
- What tasks are you no longer able to perform?
- Describe your work situation before your leave of absence: schedule, overtime, work environment, etc.

Return to Work and Accommodations

- What could make your return to work easier? What is your perspective on this?
- Are there any accommodation options available through your employer?

Supplementary Income

- Do you have other sources of income or receive other benefits (e.g., second job, mortgage insurance)?

For participants aged 55 and older

- Have you already set a date for your retirement?

In some cases, following this discussion, you may be asked to provide additional documents. Processing of your claim will be suspended until these are received.

4. How will I be notified of the decision?

Once all documents have been received and reviewed, the client relation specialist will contact you again by phone to inform you of the outcome of the process. The decision will also be sent to you in writing. When the claim is approved, the Insurer will deposit your benefits into your bank account within 24 to 48 business hours.

5. Can the Insurer offer me rehabilitation services?

Depending on your situation, the Insurer may offer you support from rehabilitation health professionals to help you recover. These professionals are specifically trained to help people who have been disabled for a certain period regain a better quality of life, while respecting their health condition. The costs associated with these professionals will be covered by the Insurer as part of the management of your disability claim.

If you wish to consult professionals who are not included in your treatment plan, you may do so at your own expense, through your group insurance plan.

6. How does the return-to-work process work?

If your doctor confirms that you are able to return to work or to begin on-the-job rehabilitation, you must notify the Insurer to have the doctor's proposed plan approved. You will also need to reach an agreement with your employer and notify your local union representative, if necessary, to agree on the terms of your return to work.

The Insurer generally agrees to support a gradual return to work in order to help you regain your health. However, the Insurer must approve the duration of this period in advance. Under no circumstances may this period exceed 12 months, including any gradual return to work that takes place during the elimination period for long-term disability insurance. During this period, a portion of your disability insurance benefits will continue to be paid to you in addition to the wages received from your employer for the time worked.

Duty to Accommodate

Your doctor may recommend a return to work under certain conditions. If these conditions require accommodations, the employer must seek a reasonable solution, unless doing so would impose an undue hardship. During the accommodation process, you must cooperate with the employer and your local union. Contact your local union so that it can support you throughout this process.

7. Frequently Asked Questions

a) What happens once I've filed my application for short-term or long-term disability insurance?

A client relation specialist will be assigned to your claim. They will review the documents received, contact you for the initial interview, and determine, in accordance with the terms of the FNEEQ contract, your eligibility to receive disability insurance benefits.

They will contact you by phone, and you will then receive a written notice informing you of the decision.

b) What information is considered when reviewing my claim?

The review of your case considers all medical information received as well as additional information gathered during the telephone interview.

c) Do I continue to pay my insurance premiums during my period of disability?

The FNEEQ group insurance policy includes a premium waiver clause, which means you no longer have to pay premiums after a certain period.

If you have short-term disability insurance coverage with Beneva, the short-term disability premium waiver applies on the first day of the pay period following the date benefits begin.

However, if your employer pays you the sick leave benefits provided for in the collective agreement, the premium waiver takes effect after a period of 52 weeks following the onset of disability.

Special provisions apply to senior lecturers at Université Laval. For more details, please consult the Schedule of coverage.

The premium waiver for insurance coverage remains in effect as long as you meet the definition of disability provided for in the contract, as long as that the contract remains active and you have not reached the age of 65.

d) Is my application for disability benefits automatically approved?

It is important to note that disability is not defined solely by a diagnosis or the presence of symptoms. Your health condition must also meet the definition of total disability provided for in your group insurance policy.

e) What can I do if my application for disability benefits is denied?

If your claim is denied and you disagree with the decision, you may request, within 30 business days, a review of the initial decision. A specialized team will handle your case.

You can view the page explaining the complaint handling and dispute resolution process at the following address: <https://www.beneva.ca/en/issues-and-complaints>.

Your appeal must be submitted to the Insurer in accordance with the procedures outlined in the *"How to File a Complaint?"* section of the website. Ideally, it should be accompanied by new medical information to support your request for reconsideration, although this is not mandatory.

You are responsible for all costs related to medical examinations and the production of new documents (e.g., medical records, specialist medical reports).

If, after your file has been reviewed, you remain dissatisfied with the Insurer's decision, other avenues of appeal are available. These are detailed on the dedicated webpage, and you may contact your union for more information.

f) When will I receive my first payment?

You must enroll in direct deposit for your benefits by including a sample check with your application. This process allows the Insurer to pay you quickly once your application is approved.

Depending on your financial institution, it may take 24 to 48 business hours for the funds to be deposited into your bank account. Thereafter, the payment for the current month is made at the end of that month.

g) Are the disability benefits I receive taxable?

Disability benefits are non-taxable.

h) What are my responsibilities as an insured person?

As part of your initial claim for benefits, it is your responsibility to submit all relevant, duly completed documents to the Insurer.

Once your disability has been recognized, you must provide the Insurer, upon request, with any additional medical documents or information that the Insurer deems relevant.

i) Will the Insurer contact me during my period of disability?

During your period of disability, the client relation specialist handling your case may contact you to gather information about the progression of your health condition, your

functional abilities, and your progress, in order to assess whether to extend your claim coverage and to inform you of the next steps.

A clear understanding of your situation allows Beneva to refer you to other health services or health experts as needed, all with the goal of helping you regain your health.

j) Who should I contact if I have questions about my disability insurance?

If your questions concern benefits payable by the Insurer, **please contact them at 1-800-463-4856.**

However, if your questions relate to wage replacement benefits payable by your employer, you should contact your employer.

You can also contact your local union at any time.

k) Do I continue to contribute to RREGOP during my disability?

You will be exempt from RREGOP contributions for a maximum period of three years, unless there are special circumstances. If the disability lasts longer, your collective agreement provides for certain terms regarding the buyback of your years of service. For more information, contact your union.

l) Can I receive assistance from Retraite Québec in the event of permanent disability?

The insurer notifies the FNEEQ when an individual is recognized as permanently disabled in their job. A FNEEQ representative may contact you to offer assistance with your procedures, if you wish.

Group insurance is about solidarity!

Our group insurance plan accepts all eligible members, regardless of their health condition, and shares among them the risk that one of them may become ill. Everyone agrees to pay a portion of the cost, and if a person requires care or becomes disabled, benefits may be paid to them.

In a large organization such as the FNEEQ, premium rates are based on the claims filed by its members. That is why, when total claims exceed the total premiums paid by members, the rates increase the following year. On the contrary, if claims are lower than what was anticipated in the premium rate structure, under the financial agreement, the surplus funds are deposited into an account where they are available to the FNEEQ, which may, for example, use them to grant a premium holiday to members the following year or a subsequent year to mitigate a premium increase.

In this context, it is important to ensure that all members are treated fairly, in accordance with the contract's rules. This is the mandate that the FNEEQ has entrusted to the Insurer.

