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Keep original forms for your records.



GROUP INSURANCE - DISABILITY CLAIMS

**DISABILITY OR WAIVER OF PREMIUM CLAIM  
EMPLOYER STATEMENT****A - IDENTIFICATION****We are unable to assess this claim unless all questions are answered completely.**

<b>EMPLOYEE</b> Last name and first name	Certificate or identification no.	Social insurance no.*
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Address of employee - No., street, apt.	City	Province	Postal code
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Telephone no.: ( ) -	E-mail address:
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<b>POLICYHOLDER OR EMPLOYER</b> Name	Policy or group or contract no.	Division no.
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Address of policyholder or employer - No., street, suite	City	Province	Postal code
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Telephone no.: ( ) -	Fax no.: ( ) -
YYYY MM DD	YYYY MM DD

<b>COMPLETE IF SELF-ADMINISTERED:</b> Effective date of coverage:	Class no.:
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\* Social insurance number is necessary only if the disability claims are taxable.

**B - GENERAL INFORMATION****If the benefits are taxable, the basic tax deductions will be made.  
In all other cases, please provide the appropriate tax forms.**

<b>1</b> Current salary Amount <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every two weeks \$	<b>2</b> Salary effective date YYYY MM DD	<b>3</b> Job status <input type="checkbox"/> Full time <input type="checkbox"/> Part time
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<b>4</b> Indicate days in normal work week <input type="checkbox"/> SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT Hours worked per week	<b>5</b> Type of schedule <input type="checkbox"/> Variable <input type="checkbox"/> Rotating	<b>6</b> Premium paid by <input type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> Both
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<b>7</b> Date of employment YYYY MM DD	<b>8</b> Occupation	<b>9</b> Date last worked YYYY MM DD	No. of hours worked
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<b>10</b> Is disability due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", date of accident:
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<b>11</b> Did or will the employee receive any income during the disability period? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)	
Type:	Amount: \$
Period:	

<b>12</b> If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (Québec only)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>13</b> Has a claim been filed with a government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", indicate below:
<input type="checkbox"/> CNESST / WCB / WSIB / WHSCC <input type="checkbox"/> CPP / QPP <input type="checkbox"/> SAAQ (Québec only)	
<input type="checkbox"/> Other, specify: _____	

Date Filed:	Decision Rendered:	Amount: \$
YYYY MM DD	YYYY MM DD	

<b>14</b> Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", on what date?
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<b>15</b> Is this person still in your employ? <input type="checkbox"/> Yes <input type="checkbox"/> No - Termination date:	Reason:
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<b>16</b> Was this person given a record of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>17</b> Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work?
<input type="checkbox"/> No <input type="checkbox"/> Yes - Please specify: _____

<b>18</b> Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please indicate the percentage of employment income that is not taxable: %

**PLEASE COMPLETE THE BACK OF THE FORM.**

**C - PHYSICAL WORK ENVIRONMENT**

Please attach a brief job description if available.

1 What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties	%	Duties	%
Duties	%	Duties	%

For questions 2 and 3, FREQUENCY is defined as follows:

OCCASIONALLY: 0-15 % of the times      FREQUENTLY: 16-50 % of the time      ALWAYS: 51 % + of the time

2 Work environment - Does the employee's job require work in any of the following conditions?

<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>
<input type="checkbox"/> Outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In a damp or humid environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Above or below ground level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In extremes of cold or heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Toxic fume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Handling chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the job involve other hazards?     Yes     No    If "Yes", please list:

3 Check the items below that relate to the employee's job, and complete the information requested.

<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Extending/reaching above head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stairs (No. of steps _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keeping one's balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ladders (Height _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY:	O	F	A	WEIGHT:
<input type="checkbox"/> Pushing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg
<input type="checkbox"/> Pulling _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg
<input type="checkbox"/> Lifting/carrying _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment	Times per day
Type of equipment	Times per day

4 Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines?     Yes     No

If "Yes", please specify: \_\_\_\_\_

5 Does the employee's job require dexterity?     Yes     No

If "Yes", please specify: \_\_\_\_\_

**D - ADDITIONAL INFORMATION**

**SIGNATURE OF THE AUTHORIZED PERSON**

_____	_____
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
_____	_____
E-mail address	
_____	_____
Signature	Date