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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.**

EMPLOYEE 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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POLICYHOLDER OR EMPLOYER 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

COMPLETE IF SELF-ADMINISTERED: 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.**

1 Current salary <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every two weeks	Amount \$	2 Salary effective date YYYY MM DD	3 Job status <input type="checkbox"/> Full time <input type="checkbox"/> Part time
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4 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	5 Type of schedule <input type="checkbox"/> Variable <input type="checkbox"/> Rotating	6 Premium paid by <input type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> Both
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7 Date of employment YYYY MM DD	8 Occupation	9 Date last worked YYYY MM DD	No. of hours worked
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10 Is disability due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", date of accident:
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11 Did or will the employee receive any income during the disability period? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", indicate below:
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Type:	Amount: \$	Period:
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12 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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13 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"/> Other, specify: _____	<input type="checkbox"/> SAAQ (Québec only)

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

14 Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", on what date?
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15 Is this person still in your employ? <input type="checkbox"/> Yes <input type="checkbox"/> No - Termination date:	Reason:
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16 Was this person given a record of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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17 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: _____

18 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?

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
<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.

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
<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:

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