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**Insurance**

Life • Health • Retirement

GROUP INSURANCE – DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM**EMPLOYER STATEMENT****Section A. Identification** (we will only assess this claim if all fields are completed)

Last and first name of employee		Certificate or identification No.	Social insurance No.*
Address of employee – No., street, apt.		City	Province
			Postal code
Phone No.:		Personal email address	
Name of policyholder or employer		Policy, group or contract No.	Division No.
Address of policyholder or employer – No., street, suite		City	Province
			Postal code
Phone No.:			

Complete if self-administered

YYYY MM DD

Effective date of coverage:

Class No.:

* The social insurance number is only required if the benefit payments are taxable.

Section B. General information

If the benefit payments are taxable, basic tax deductions will be made. In all other cases, please provide the appropriate tax forms.

Current salary		Amount	Effective date of salary	Job status
☐ Weekly ☐ Monthly ☐ Every two weeks			YYYY MM DD	☐ Full time ☐ Part time
Workdays in a standard week		Hours worked per week	Type of schedule	
☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT			☐ Variable ☐ Rotating ☐ Fixed	
Date of employment	Occupation	Last day of work	No. of hours worked	
YYYY MM DD		YYYY MM DD		
Is the disability due to an accident? ☐ Yes ☐ No If yes, date of accident:				
Has any amount been paid to the insured person since the start of their absence and outside the waiting period? ☐ Yes ☐ No				
If yes, select all types of amounts paid:				
☐ Bonus or lump sum ☐ Sick leave ☐ Salary ☐ Vacation				
☐ Other, please specify _____				
Has a claim been filed with a workers' compensation board? ☐ Yes ☐ No				
Has the employee returned to work? ☐ Yes ☐ No If yes, on what date? _____				
What will the employee's schedule be when they return to work? ☐ Regular schedule ☐ Modified schedule				
What kind of tasks will they perform? ☐ Usual tasks ☐ Modified tasks				
Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☐ Yes ☐ No				
If so, please indicate the percentage of employment income that is not taxable _____ %				

Please complete the back of the form.

Section C. Circumstances relating to the absence (please attach a brief job description if available)

Could a work-related situation have contributed to the insured person's absence? ☐ Yes ☐ No

If yes, select all situations that apply:

- | | | |
|--|---|--|
| ☐ Conflict (with a coworker or manager) | ☐ End of employment (resignation, dismissal, retirement, etc.) | |
| ☐ Temporary layoff, strike or lockout | ☐ Performance issues | ☐ Denied vacation |
| ☐ Work overload | ☐ Suspension with or without pay | |
| ☐ Other, please specify _____ | | |
-
-
-
-

Signature of the authorized person

Last and first name of the authorized person (IN BLOCK LETTERS)

Position

Email address

Signature

Date

Are you the contact person during the absence? ☐ Yes ☐ No

If no, please provide the contact person's details:

Name _____

Position _____

Email address _____

Professional phone number _____

Are there other people who should be included in communications with the insurer during the disability leave?

☐ Yes ☐ No

Name _____

Position _____

Email address _____

Professional phone number _____

Name _____

Position _____

Email address _____

Professional phone number _____

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