# Chambers of Commerce Group Insurance Plan®

# Long Term Disability Claim

Any absence from work on either a short or long term basis as a result of illness or accident can be a stressful period, particularly if your income is affected. In order to facilitate the filing of your claim for Long Term Disability Benefits, Business Overhead Expense Benefits and Waiver of Premium Benefits, and to minimize the delay in releasing the initial payment, we have prepared this package to assist you. For your convenience a checklist is included below. If any questions arise as you prepare or secure the requested information, please call us on our toll-free line, 1-800-665-3365 between 8 a.m. and 5 p.m. CST, Monday through Friday, to speak with a Disability Customer Service Representative. Please note that on approval all benefits are paid monthly in arrears.

All forms must be as complete as possible and **ALL REQUIRED INFORMATION MUST BE SUBMITTED BEFORE PROCESSING OF THE APPLICATION CAN COMMENCE**. The decision rendered will be based on the information provided. Regrettably, incomplete forms or insufficient documentation will compromise our ability to achieve a timely decision on your claim. Should this happen you will be advised in writing of the status of your claim.

**When complete, this claim may be:**

- faxed to 1-800-457-8410,
- emailed to chdisability@johnstongroup.ca, or
- mailed to
  **Chambers of Commerce Group Insurance Plan**
  1051 King Edward Street, Winnipeg, MB R3H 0R4
  Attn: Disability Claims Department

## FINANCIAL EVIDENCE

Earned Income is the income earned for services performed by the insured. Please include the financial evidence, as outlined, with your claim.

### EMPLOYEES

Employee Income may be in the form of salaries and wages, bonuses, commissions, fees and honorariums. Please attach copies of your T4 slips for the past two years.

Income as reported to Canada Revenue Agency on your T1 Income Tax returns will be used to calculate your Earned Income and your benefits payable.

### OWNERS / SELF-EMPLOYED INDIVIDUALS

Income may be in the form of salaries and wages, bonuses, company dividends (average over the last two years from T5), commissions, or the net income from the operation of a self-employed business. Earned Income does not include interest, rental income or income from capital gains, royalties, pensions, annuities, deferred compensation or any other income that does not depend upon the ability of the insured to perform services or any occupation.

Net Income is the gross income of the business, less any business expenses that can be claimed for income tax purposes, except income taxes payable on such income. **Please attach copies of pages 1 and 2 of your tax returns, along with tax schedules detailing income reported on lines 135 to 143, for the past two years.**

Income as reported to Canada Revenue Agency on your T1 Income Tax returns will be used to calculate your Earned Income and your benefits payable.

## CHECKLIST FOR SUBMITTING A DISABILITY CLAIM

Make sure you have done all of the following:

- ❑ completed the forms in ink.
- ❑ each section of the forms is completed by the appropriate person.
- ❑ signed and dated all sections of the forms.
- ❑ enclosed all the required forms for your claim including a copy of your Birth Certificate, passport or Baptismal Certificate.

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# Long Term Disability Claim – Employer's Statement

**(TO BE COMPLETED BY THE EMPLOYER. IF SELF-EMPLOYED, THEN BY THE CLAIMANT.)**

Head Office Only: Group # _____

## 1) THE EMPLOYER OR POLICYHOLDER

Company Name _____ Language Preference ❑ English ❑ French

Address _____ Firm No. _____

City _____ Province _____ Postal Code _____ Phone (_____) _____

Industry _____ Fax (_____) _____

Primary Products/Service _____ E-mail Address _____

Contact Name _____

## 2) THE CLAIMANT

This is a ❑ Long Term Disability Claim ❑ Life Insurance Premium Waiver ❑ Business Overhead Expense Claim

Employee's Last Name _____ Date of Birth (DD/MM/YY) _____

Employee's Given Name(s) _____ Certificate No. _____

## 3) THE CLAIMANT'S EMPLOYMENT

1. a) Date employee was hired (DD/MM/YY) _____ Date employee became insured under this plan (DD/MM/YY) _____

   b) Last date employee worked (DD/MM/YY) _____

   Date employee would have next worked if absence from work had not begun (DD/MM/YY) _____

2 a) Permanent position on last date worked? _____ Length of time in that position? _____

   b) If less than one year please provide a list of positions held since the date of hire _____

3. On the employee's last date worked, was it a full day? ❑ Yes ❑ No If "No", how many hours were worked? _____

4. Why did the employee stop working? _____

5. Has the employee returned to work for any period of time since the last date worked? ❑ Yes ❑ No If "Yes", provide details:

6. Employment Class (please check one box **in each row that is applicable**)

   a) ❑ Full-time ❑ Part-time

   b) ❑ Permanent ❑ Temporary ❑ Seasonal

   c) ❑ Hourly ❑ Salaried ❑ Commissioned

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# Long Term Disability Claim – Employer's Statement

**3) THE CLAIMANT'S EMPLOYMENT (CONTINUED)**

7. What are the regular hours worked on an average day excluding overtime? _____ AM/PM to _____ AM/PM

8. Please indicate one complete average work week or shift cycle by showing the number of hours worked per day.

| Day of week | S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|---|
| Hours | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Indicate "0" for days off.

Does the cycle repeat? ❑ Yes ❑ No

Average number of hours worked per week _____

9. a) How many days was the employee absent from work in the six months prior to the disability date (excluding vacation and statutory holidays). _____
   b) Has this employee had any prior claims? ❑ Yes ❑ No If "Yes" please provide details: (e.g. short term disability, long term disability, workers' compensation board)

_____

_____

10. a) Is this work subject to: Seasonal Changes ❑ Yes ❑ No
    Business Cycles ❑ Yes ❑ No
    Layoffs ❑ Yes ❑ No
    b) If "Yes" to any of the above, please describe how the work is affected, including the cause, frequency and usual type of occurrence, the effect on the number of hours or days worked per week, the average number of months that the employee works per year, the type of employment (casual, seasonal, on-call, apprentice, etc.)

_____

_____

11. In the last year:
    a) Were there any changes to the employee's responsibilities prior to ceasing work? ❑ Yes ❑ No
    b) Have there been any changes with regard to who he/she reports to? works with? ❑ Yes ❑ No
    c) Have there been any changes in attendance? ❑ Yes ❑ No
    d) Have there been any changes in job duties? ❑ Yes ❑ No
    e) Have there been any performance issues? ❑ Yes ❑ No
    f) Do you consider your employee's condition to be work related? ❑ Yes ❑ No

    If "Yes" to any of the above, please provide an explanation and attach any supporting documentation. (eg. Copies of attendance records, written performance concerns, etc.)

_____

_____

12. a) Has a claim been filed for workers' compensation board benefits? ❑ Yes ❑ No
    If "Yes", provide workers' compensation board information:

    Claim No. _____ Name of Contact _____ Phone (_____)_____

    b) If workers' compensation board benefits have been approved, what services/activities are being provided to assist this employee? (eg., assessment, retraining, vocational rehabilitation, return to work trials, etc.).

_____

_____

    c) If "No", and if work related, explain why claim has not been filed.

_____

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# Long Term Disability Claim – Employer's Statement

## 4) INSURANCE INFORMATION

1. Other insurers for your company:

| | Name | Address (Street, City, Province, Postal Code) | Policy No. |
|---|---|---|---|
| **Short Term Disability** | | | |
| **Extended Health Care** | | | |

2. a) Did your company have Long Term Disability insurance coverage immediately prior to this policy? ❑ Yes ❑ No If "Yes", please provide details on the prior insurance carrier:

   Name of Previous Insurer _____ Policy _____ Effective Date (DD/MM/YY) _____

   b) Was this employee covered with the previous carrier? ❑ Yes ❑ No If "Yes", please provide effective date of coverage: (DD/MM/YY) _____

3. Was coverage under this plan added for this employee on the first date they were eligible? ❑ Yes ❑ No If "No", explain

   _____

   _____

4. Has the employee's coverage been continuous since first insured under the plan? ❑ Yes ❑ No

   If "No", indicate the coverage interruptions and reasons for them. _____

   _____

5. a) Has coverage under this policy terminated for this employee? ❑ Yes ❑ No If "Yes", what is the date of termination? (DD/MM/YY) _____

   b) Why was it terminated? _____

   _____

## 5) RETURN TO WORK POLICIES

1. a) Is this employee's job still available? ❑ Yes ❑ No

   b) If "yes", whom should we contact to verify vocational rehabilitation or return to work potential?

   Name _____ Title/Position _____ Phone (_____)_____

## 6) THE CLAIMANT'S INCOME (IF YOU ARE SELF EMPLOYED AND HAVE COMPLETED FINANCIAL EVIDENCE IN THIS PACKAGE PLEASE GO TO SECTION 7)

1. Prior to the last date worked:

   Hourly Wage $_____ Annual Salary $_____ Pay Period (Bi-weekly, Monthly, etc.) _____

2. In the 12 months (or the period of employment if less than 12 months) prior to the last date worked, what was the amount paid to the employee for:

   Commission $_____ Bonuses $_____ Overtime $_____

3. Deductions ❑ Weekly ❑ Bi-Weekly ❑ Monthly

| | Income Tax Exemption Code | Tax Withheld at Source | CPP/QPP Contribution | EI Contribution |
|---|---|---|---|---|
| **Federal** | | | | |
| **Provincial** | | | | |

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# Long Term Disability Claim – Employer's Statement

## 7) OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

| | SOURCE OF INCOME | SOURCE OF INCOME | SOURCE OF INCOME |
|---|---|---|---|
| | ❑ Employment Insurance<br>❑ Other Group Plan<br>❑ Canada/Quebec Pension Plan<br>❑ Worker's Compensation Board<br>❑ Automobile Insurance<br>❑ Other _____ | ❑ Employment Insurance<br>❑ Other Group Plan<br>❑ Canada/Quebec Pension Plan<br>❑ Worker's Compensation Board<br>❑ Automobile Insurance<br>❑ Other _____ | ❑ Employment Insurance<br>❑ Other Group Plan<br>❑ Canada/Quebec Pension Plan<br>❑ Worker's Compensation Board<br>❑ Automobile Insurance<br>❑ Other _____ |
| Name of Company | | | |
| Policy Number | | | |
| Amount (per week / month) | | | |
| Date Claim Filed | | | |
| Date Payment Begins / Began | | | |
| Date Payment Ends / Ended | | | |

## 8) CLAIMANT'S OCCUPATION

1. Please describe the occupation of the Claimant immediately prior to stopping work. If employed in more than one occupation, please include all occupations.

| Job Title (if different from occupation) | Customary Hours (include breaks/lunch) | Days Worked S M T W T F S | Number of Employees Supervised |
|---|---|---|---|
| | | ❑ ❑ ❑ ❑ ❑ ❑ ❑ | |
| | | ❑ ❑ ❑ ❑ ❑ ❑ ❑ | |
| | | ❑ ❑ ❑ ❑ ❑ ❑ ❑ | |

2. Briefly describe the claimant's position. _____

3. Describe the tasks involved in performing the job.

| | Hours/Week |
|---|---|
| | |
| | |
| | |
| | |

4. Can the position be performed on a part-time basis? ❑ Yes ❑ No
5. Minimum Qualifications: _____
6. Licenses/Certificates Required: _____
7. Machines/Tools/Equipment Used: _____
8. Titles of Direct Reports: _____
9. Name/Title of Supervisor _____ Supervisor's Telephone No. _____

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## 9) PHYSICAL DEMANDS

**For the following table FREQUENCY is defined as follows:**
OCCASIONALLY: 0-15% of the time FREQUENTLY: 16-50% of the time ALWAYS: 51+% of the time

Check the items below that relate to your job

| Task | Frequency | | | Task | Frequency | | |
|---|---|---|---|---|---|---|---|
| | Occasionally | Frequently | Always | | Occasionally | Frequently | Always |
| Standing | ❑ | ❑ | ❑ | Jumping | ❑ | ❑ | ❑ |
| Walking | ❑ | ❑ | ❑ | Bending | ❑ | ❑ | ❑ |
| Sitting | ❑ | ❑ | ❑ | Twisting | ❑ | ❑ | ❑ |
| Stoop / Crouch / Squat | ❑ | ❑ | ❑ | Throwing | ❑ | ❑ | ❑ |
| Kneeling | ❑ | ❑ | ❑ | Balancing | ❑ | ❑ | ❑ |
| Climbing | ❑ | ❑ | ❑ | Extending/reaching above head | ❑ | ❑ | ❑ |
| Crawling | ❑ | ❑ | ❑ | | | | |
| Pushing | ❑ | ❑ | ❑ | weight: _____ ❑ lbs. ❑ kgs. | | | |
| Pulling | ❑ | ❑ | ❑ | weight: _____ ❑ lbs. ❑ kgs. | | | |
| Lifting / carrying | ❑ | ❑ | ❑ | weight: _____ ❑ lbs. ❑ kgs. | | | |
| Handle / Grasp | ❑ | ❑ | ❑ | ❑ left hand ❑ right hand ❑ both | | | |
| Fine Manipulation | ❑ | ❑ | ❑ | ❑ left hand ❑ right hand ❑ both | | | |
| Power Grip | ❑ | ❑ | ❑ | ❑ left hand ❑ right hand ❑ both | | | |

2. a) Operation of Foot Controls? ❑ Yes ❑ No

   b) Type of Equipment _____

   Cumulative Hours per Day _____ Longest Period Performed Without a Break _____

3. Can this job be performed alternately sitting and standing? ❑ Yes ❑ No

## 10) COGNITIVE WORK FUNCTIONS

| Do Essential Tasks Require: | Yes | Hours/Week | No |
|---|---|---|---|
| 1. Working with others? | ❑ | _____ | ❑ |
| 2. Working alone, apart or in physical isolation from others? | ❑ | _____ | ❑ |
| 3. Comprehending and following instructions? | ❑ | _____ | ❑ |
| 4. Performing simple and repetitive tasks? | ❑ | _____ | ❑ |
| 5. Performing complex or varied tasks requiring higher level of reasoning, language and/or math? | ❑ | _____ | ❑ |
| 6. Working under deadlines? | ❑ | _____ | ❑ |
| 7. Working frequently in excess of normal work hours? | ❑ | _____ | ❑ |
| 8. Performing varied work tasks with frequent interruptions? | ❑ | _____ | ❑ |
| 9. Dealing with an angry/upset/combative public? | ❑ | _____ | ❑ |
| 10. Dealing with others who have experienced traumatizing events? | ❑ | _____ | ❑ |
| 11. Supervising others? | ❑ | _____ | ❑ |
| 12. Being responsible for others' output/work product? | ❑ | _____ | ❑ |
| 13. Influencing others beyond giving simple information or directions? | ❑ | _____ | ❑ |

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# Long Term Disability Claim – Employer's Statement

## 10) COGNITIVE WORK FUNCTIONS (CONTINUED)

| Do Essential Tasks Require: | Yes | Hours/Week | No |
|---|---|---|---|
| 14. Making generalizations, evaluations or decision without immediate supervision? | ❑ | _____ | ❑ |
| 15. Carrying out responsibility for direction, control & planning? | ❑ | _____ | ❑ |
| 16. Performing when confronted with emergency, critical, unusual or dangerous situations? | ❑ | _____ | ❑ |
| 17. Sustained attention to complex tasks? | ❑ | _____ | ❑ |

## 11) ENVIRONMENTAL DEMANDS

| Is the Claimant Exposed to: | Yes | Hours/Week | No |
|---|---|---|---|
| 1. Weather? | ❑ | _____ | ❑ |
| 2. Extreme cold? | ❑ | _____ | ❑ |
| 3. Extreme heat? | ❑ | _____ | ❑ |
| 4. Wet and/or humid (non-weather) | ❑ | _____ | ❑ |
| 5. Noise Intensity Level | | | |
| Very Quiet (isolation)? | ❑ | _____ | ❑ |
| Quiet (Library)? | ❑ | _____ | ❑ |
| Moderate (Office)? | ❑ | _____ | ❑ |
| Loud (Manufacturing)? | ❑ | _____ | ❑ |
| Very Loud (Jackhammer)? | ❑ | _____ | ❑ |
| 6. Poor Lighting | ❑ | _____ | ❑ |
| 7. Poor Ventilation | ❑ | _____ | ❑ |
| 8. Vibration | ❑ | _____ | ❑ |
| 9. Fumes, Odours, Dust, Gases? | ❑ | _____ | ❑ |
| 10. Proximity to moving mechanical parts? | ❑ | _____ | ❑ |
| 11. Exposure to electric shock? | ❑ | _____ | ❑ |
| 12. Working in high, exposed places? | ❑ | _____ | ❑ |
| 13. Exposure to radiation? | ❑ | _____ | ❑ |
| 14. Working with explosives? | ❑ | _____ | ❑ |
| 15. Exposure to toxic or caustic chemicals? | ❑ | _____ | ❑ |
| 16. Working on uneven ground? | ❑ | _____ | ❑ |

If "Yes", what type? _____

17. Travel? If "Yes", by what means? ❑ Car ❑ Plane ❑ Train
18. Other? If "Yes", explain: _____

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# Long Term Disability Claim – Employer's Statement

## 12) ACCOMMODATIONS AND MODIFICATIONS

What type of alterations and modifications have been made to the work environment for this position in the past or could be made in the future to assist in returning the Claimant to work? _____

_____

_____

Name of Contact _____ Title _____ Phone (_____)_____

## SIGNATURE OF PERSON COMPLETING THIS FORM

I, _____ (please print), verify that the above statements are true and complete to the best of my knowledge and belief.

Signature _____ Date (DD/MM/YY/) _____