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.

Understanding Your Chambers of Commerce Group Insurance Plan Long Term Disability Claim

Any absence from work on a long term basis as a result of illness or accident can be a stressful period, particularly if your income is affected. We have prepared this summary to help you better understand the steps involved in making a disability claim, and what happens after you submit the claim.

How do I qualify for LTD benefits?

You are considered to be ***totally disabled*** if you are unable, as a result of illness or injury, to perform either:

a) the whole duties of your regular occupation, or

b) any occupation for which you are or may reasonably become qualified based on your training, education and / or experience.

Your ***definition of disability*** can be found in your employee booklet. No benefits are payable for partial disabilities.

All Chambers Plan policies include a *Pre-Existing Condition* provision. This means benefits are not payable for any disability which begins within the employee's first 12 months of coverage if that disability is due, directly or indirectly, to a pre-existing condition. That is, any condition for which you were treated or attended by a physician or were prescribed drugs that were taken during the three month period immediately prior to your effective date of coverage.

Proof of income

The insurance company will require proof of your income to complete the claim assessment.

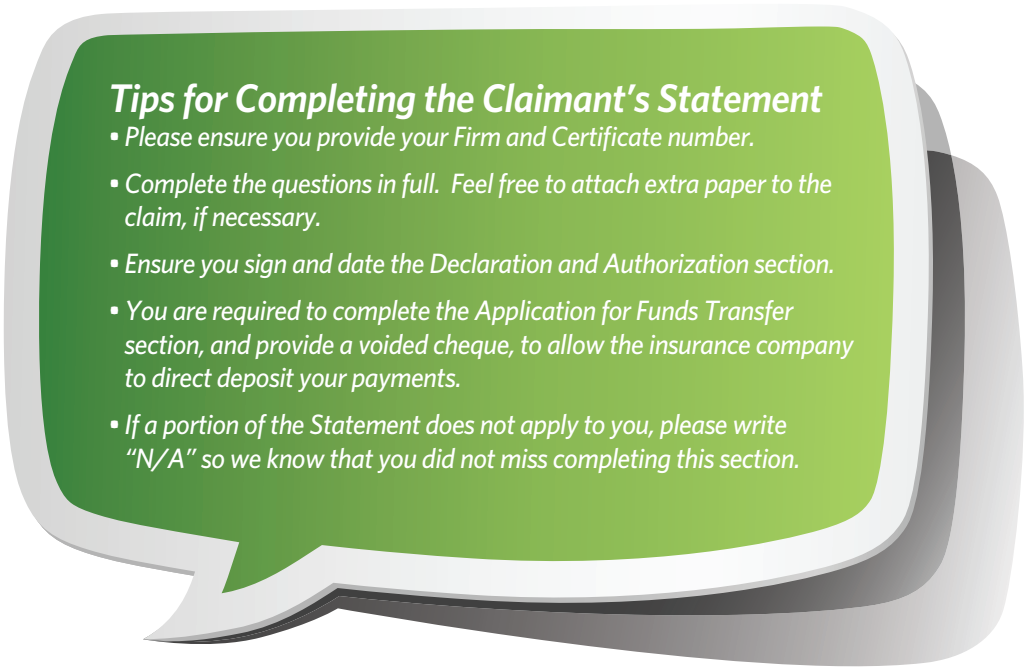
*For **employees**, please attach copies of your T4 slips for the past two years.*

*For **owners / self employed individuals**, please attach copies of pages 1 and 2 of your returns, along with tax schedules detailing income reported on lines 135 and 143, for the past two years.*

When should I apply for LTD benefits?

Under the Chambers Plan, benefits begin from the 121st day of disability, but do not wait until the end of the elimination / waiting period before filing a claim. If your disability will prevent you from returning to work, we suggest you forward completed claim forms approximately 90 days into the disability. This provides the insurance company sufficient time to review your claim and obtain any additional information required to complete the assessment.

Claims received more than 180 days after the onset of the disability may be declined due to late submission.



How do I begin?

There are three forms that must be completed as part of your claim:

- **Claimant's Statement.** This provides the insurance company with information about you, your condition, a brief medical history, and any other insurance coverage you may have.
- **Employer's Statement.** This is completed by your employer. It provides information about your employment, pay, and a description of the work you do.
- **Physician's / Specialist's Statement** which is completed by your physician. It provides information about your condition, treatment, and prognosis for returning to work.

If you are the owner of your organization, your kit will combine the *Employer's* and *Claimant's Statements* to simplify the completion of the forms.

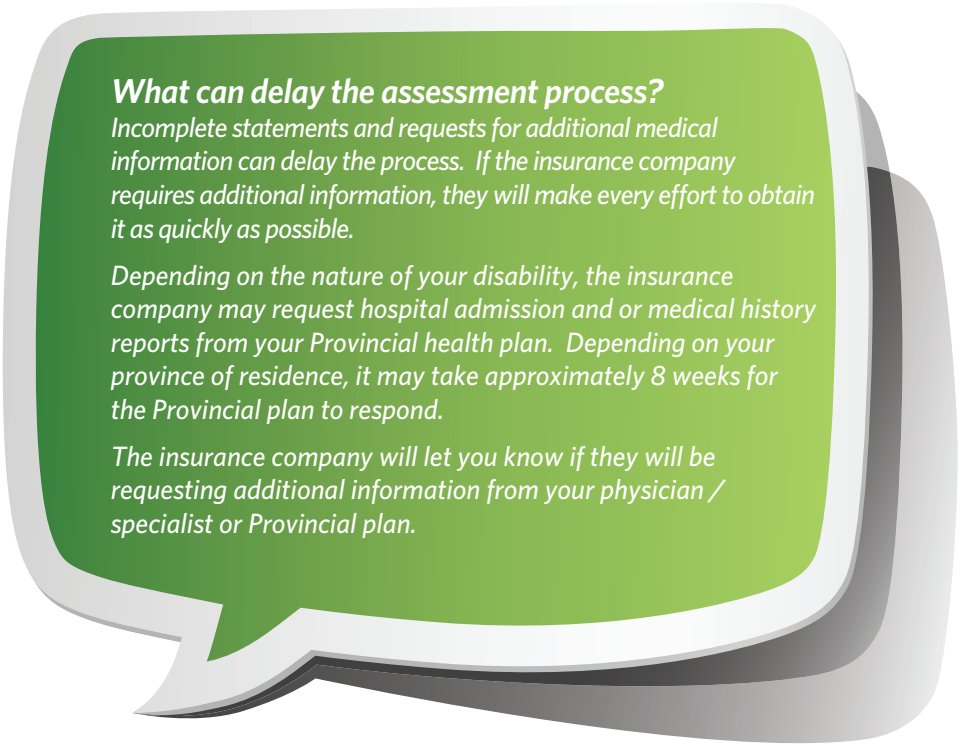
Completing the Statements

We want to make sure your claim is processed quickly and accurately so the statements are designed to collect as much necessary information as possible at the beginning of the process. We recognize the statements are quite detailed, but by ensuring they are filled correctly and completely, it will take the insurance company less time to assess and make a decision on your claim.

Completing the Statements (continued)

Please ensure:

- Statements are completed in ink.
- Each section of the form is completed by the appropriate person.
- All sections are signed and dated.
- All required forms are enclosed including a copy of your Birth Certificate, passport or Baptismal Certificate. As our plans only provide LTD benefits until age 65, it is important that we confirm the date this will occur.



Claimant's / Employer's Statement

Return the *Claimant's* and *Employer's Statement* to our office. If you wish to protect your privacy, you can send us your competed *Claimant's Statement* and your employer can return their section to us under separate cover.

Physician's / Specialist's Statement

Complete section 1 of the form and give the Statement to your physician to complete. The physician can forward the completed form directly by fax to 1-800-457-8410, or by email to chdisability@johnstongroup.ca.

You are responsible for any charges for having the *Physician's Statement* completed and any other medical statements that may be necessary to process your claim.

What happens next?

We will send you a letter acknowledging receipt of your claim and provide you with our telephone number if you have any questions regarding your claim. We will forward your completed forms to Desjardins Insurance to process your claim.

A claims examiner will handle your file from start to finish.

The examiner will review the claim once they receive both the Employer's and Claimant's Statement and the Physician's / Specialist's Statement. In most cases the examiner will have all the information they need, but if additional information is required your examiner will contact you directly.

The examiner will review the file to confirm that you are covered by your group benefits contract for LTD benefits, confirm you meet the definition of disability within your group benefits coverage, and review your claim to confirm that you are under the care of a licensed medical doctor and receiving regular, ongoing care and treatment that is appropriate for your disability.

If your claim is approved, you will receive a letter advising you of the amount of your monthly benefit and the expected duration for which your claim will be paid. If you completed the direct deposit authorization on the application form, and provided a voided cheque, benefits will be deposited directly into your bank account as they are due. Benefits will be paid after the completion of the elimination period of your disability.

If your claim is not approved, the insurance company will notify you in writing and provide the reasons for their decision. Should you disagree with the insurance company's assessment of your claim for LTD benefits, you can appeal the decision within 30 days of the receipt date of the letter. Your appeal must be in writing and should include new medical information to support your request to reassess your claim. Any costs for obtaining new medical information, such as test results and medical reports would be at your expense.

How long does the assessment process take?

The initial assessment period takes approximately ten business days from the time they receive all statements from the required parties.

If approved, when are claim payments made?

LTD benefits are payable after each month of continued disability (30 days in arrears). Payments will continue as long as you meet the definition of total disability, as defined in your employee booklet, and are receiving appropriate treatment as recommended by your treating physician. Payments continue up to the lesser of the duration of your coverage or the month you turn age 65.

How often is medical information requested?

Depending on the nature of the medical condition, medical follow-ups will be requested on a periodic basis. The frequency will depend on your condition.

How much will my LTD payments be?

Monthly LTD payments are based on a percentage of your income. Benefits will equal the lesser of the amount shown on your Certificate of Insurance and the benefits payable based on your income at the time you became disabled.

Benefits may be reduced by payments received from other sources for the same disability such as CPP / QPP and Worker's Compensation. As CPP / QPP benefit payments are part of your total benefit calculation, the insurance company may ask you to apply for these benefits once you have been approved for LTD benefits. Benefits are not reduced by income you receive from an individual disability plan.

Questions?

Contact your claim examiner by calling the number they provided you, or contact a **Chambers Plan Disability Customer Service Representative at 1.800.665.3365 or by email at chdisability@johnstongroup.ca**.

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

Head Office Only: Group # _____

1) THE COMPANY

Company Name _____

Address _____ Firm No. _____

City _____ Province _____ Postal Code _____ Telephone No. _____

Industry _____ Fax No. _____

Primary Products/Service _____ E-mail Address _____

This company is ❑ a sole proprietorship ❑ a partnership ❑ incorporated. What is your percentage of ownership? _____%

2) INFORMATION ABOUT YOU

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Other ❑ Male ❑ Female

Last Name _____ Language Preference ❑ English ❑ French

Given Name(s) _____ Date of Birth (DD/MM/YY) _____

Name Commonly Used _____ Telephone No. _____

Address _____ Fax No. _____

City _____ Province _____ Postal Code _____ E-mail Address _____

Mailing Address (if different from above) _____ Firm and Certificate No. _____

_____ Social Insurance No. _____

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

3) YOUR EMPLOYMENT

1. a) Date you started working for this company (DD/MM/YY) _____

   Date you became insured under this plan (DD/MM/YY) _____

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

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

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

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

_____

_____

CONTINUED NEXT PAGE

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

3) YOUR EMPLOYMENT (CONTINUED)

4. Employment Class (please check one box in each row that is applicable)
   a) ❑ Full-time ❑ Part-time
   b) ❑ Permanent ❑ Seasonal ❑ Business Cycles
   c) If seasonal or business cycles, please describe how the work is affected, including the number of hours or days worked per week and the average number of months worked per year.

_____

_____

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

6. 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 _____

7. In the last year:
   a) Were there any changes to your responsibilities prior to ceasing work? ❑ Yes ❑ No
   b) Have there been any changes in attendance? ❑ Yes ❑ No
   c) Have there been any changes in job duties? ❑ Yes ❑ No
   d) Do you consider your condition to be work related? ❑ Yes ❑ No

   If "Yes" to any of the above, please provide an explanation and attach any supporting documentation.

_____

_____

8. Is your company still in operation? ❑ Yes ❑ No Please explain

_____

_____

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

3. Has your coverage been continuous since first insured under the plan? ❑ Yes ❑ No

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

_____

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

5) YOUR INCOME

The financial evidence required in connection with your claim is listed on a separate cover sheet in the Claim Folder. This information is required to accurately determine your pre-disability income as defined in the policy provisions. Disability payments will be delayed if claims are submitted without financial evidence.

1. **If your business is a sole proprietorship or partnership**, your self-employed income is the income reported on lines 135 to 143 of your tax return. Please attach a copy of the tax schedules (included in your tax reporting package) which provide the details of the amounts reported.
2. **If your business is incorporated**, will you be receiving any reimbursement from your company while you are disabled? ❑ Yes ❑ No

   If yes, please state the monthly amount: Salaries and wages $_____ Bonuses $_____ Commissions $_____
3. Do you income split with your spouse? ❑ Yes ❑ No
   If yes, please comment on their involvement in the business and indicate the method used to determine the spouse's income percentage or dollar amount.

   _____

   _____
4. Do you expense a home office? ❑ Yes ❑ No

6) YOUR OCCUPATION

1. Please describe your occupation 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. Describe the tasks involved in performing the job.

	Hours/Week
_____	_____
_____	_____
_____	_____
_____	_____

3. Can the position be performed on a part-time basis? ❑ Yes ❑ No
4. Minimum Qualifications: _____

   _____
5. Licenses/Certificates Required: _____
6. Machines/Tools/Equipment Used: _____

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

7) 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

8) 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?	❑	_____	❑

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Long Term Disability – Owner's Statement

8) COGNITIVE WORK FUNCTIONS (CONTINUED)

Do Essential Tasks Require:	Yes	Hours/Week	No
11. Supervising others?	❑	_____	❑
12. Being responsible for others' output/work product?	❑	_____	❑
13. Influencing others beyond giving simple information or directions?	❑	_____	❑
14. Carrying out responsibility for direction, control & planning?	❑	_____	❑
15. Performing when confronted with emergency, critical, unusual or dangerous situations?	❑	_____	❑
16. Sustained attention to complex tasks?	❑	_____	❑

9) ENVIRONMENTAL DEMANDS

Are You 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?	❑	_____	❑

If "Yes", what type? _____

_____

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?	❑	_____	❑

17. Travel? If "Yes", by what means? ❑ Car ❑ Plane ❑ Train

18. Other? If "Yes", explain: _____

_____

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

10) ACCOMMODATIONS AND MODIFICATIONS

What type of alterations and modifications have been made to the work environment in the past or could be made in the future to assist you in returning to work?

11) INFORMATION ABOUT YOUR CLAIM

Should you require additional space to answer any of these questions, please attach additional pages and mark each answer with the section and page number of the question.

Is your absence from work the result of: (Please check one) ❑ Accident ❑ Illness ❑ Pregnancy (If pregnancy, please proceed to Pregnancy Section below)

For an illness or accident, please answer the following questions:

1. a) What were your first symptoms and when did you first notice them? _____

   b) What prevents you from returning to work? _____

   c) How does your current condition impact your daily living? Please provide details: _____

   d) Prior to stopping work, did your condition require you to change the way in which you performed your occupational duties? ❑ Yes ❑ No

   If "Yes", elaborate: _____

   e) Have you ever had a similar injury or illness: ❑ Yes ❑ No If "Yes", please provide details:

   Description _____

   _____ Date (DD/MM/YY) _____

   Treating Physician's Name _____ Specialty _____

   Address _____ City _____

   Province _____ Postal Code _____ Telephone No. (____) _____

   f) If you answered yes to question e, is this your current physician as well? ❑ Yes ❑ No

2. a) Have you now returned to your usual occupation? ❑ Yes ❑ No

   If "Yes", ❑ Part-Time Date (DD/MM/YY) _____ ❑ Full-Time Date (DD/MM/YY) _____

   b) If you have returned to work part-time, what specific occupational duties are you unable to perform and what prevents you from performing them?

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Long Term Disability – Owner's Statement

11) INFORMATION ABOUT YOUR CLAIM (CONTINUED)

3. Have you discussed a return-to-work plan with your attending Physician? ❑ Yes ❑ No If "Yes" provide following details:

   a) Doctor's Response: _____

   _____

   b) Your Response: _____

   _____

4. Do you believe that your occupational duties will need to be modified in some way when you return to work? ❑ Yes ❑ No If "Yes", please elaborate

   _____

   _____

5. Have you been involved in any activities for which you have received money since you became disabled? ❑ Yes ❑ No If "Yes", please provide details

   _____

   _____

If your condition is the result of an ACCIDENT, please answer the following:

1. a) Date the accident occurred: (DD/MM/YY) _____

   b) Where did the accident occur?: _____

   _____

   c) How did the accident occur?: _____

   _____

   d) When did you first see a Doctor for this accident? (DD/MM/YY) _____

   e) Was a police report made? ❑ Yes ❑ No If "Yes", name of detachment _____ Please attach a copy of the report if available.

   f) Name and address of any witnesses _____

2. a) Is this claim work related? ❑ Yes ❑ No

   b) If work related, has it been reported for Workers' Compensation Board benefits? ❑ Yes ❑ No If "Yes", what is the status of the claim?

   _____

   _____

   Workers' Compensation Board Information: Claim No. _____ Date Claim Filed (DD/MM/YY) _____

   Name of Contact _____ Telephone No. _____

   Address _____ City _____

   Province _____ Postal Code _____ Fax No. _____

   c) If work related and you have not applied, please elaborate as to why. _____

   _____

   d) If workers' compensation boards' benefits have been approved, what services/activities are being provided? (i.e. assessment retraining, vocational rehabilitation, return-to-work trials, etc.) _____

   _____

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Long Term Disability – Owner's Statement

11) INFORMATION ABOUT YOUR CLAIM (CONTINUED)

If your condition is related to PREGNANCY, answer the following:

Explain the nature of your complications, if any: _____

_____

Expected Date of Delivery or Actual Date of Delivery (DD/MM/YY) _____

1. a) What was your last day of work? (DD/MM/YY) _____

   b) What was the date you were first unable to work? (DD/MM/YY) _____

   c) On the last day you worked, did you work a full day? ❑ Yes ❑ No If "No", elaborate: _____

   _____

12) TREATMENT HISTORY

1. List all health care providers you have consulted in the last two years. This should include your current family physician, consulting physicians and specialists (eg. Psychiatrist, physiotherapists, chiropractors, psychologists, counsellors and therapists.) Begin with the most recent. List any additional health care providers on a separate page.

   a) Physician/Provider _____ Specialty _____ Date(s) Seen (DD/MM/YY) _____

   Address _____ Telephone No. _____

   City _____ Province _____ Postal Code _____ Fax No. _____

   Reason/Diagnosis _____

   b) Physician/Provider _____ Specialty _____ Date(s) Seen (DD/MM/YY) _____

   Address _____ Telephone No. _____

   City _____ Province _____ Postal Code _____ Fax No. _____

   Reason/Diagnosis _____

2. List all hospitals and health care facilities where you received treatment or attended as an outpatient. Begin with the most recent. List any additional facilities on a separate page. This should include any facility visited in the last five years.

   a) Hospital/Facility _____ Date Admitted/Started (DD/MM/YY) _____

   Address _____ Date Discharged (DD/MM/YY) _____

   City _____ Province _____ Postal Code _____

   Reason _____

   b) Hospital/Facility _____ Date Admitted/Started (DD/MM/YY) _____

   Address _____ Date Discharged (DD/MM/YY) _____

   City _____ Province _____ Postal Code _____

   Reason _____

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Employee Benefits

Long Term Disability – Owner's Statement

12) TREATMENT HISTORY (CONTINUED)

3. List all pharmacies where you fill your prescriptions.

Name of Pharmacy	Address (Street, City, Province, Postal Code)	Telephone No.

4. a) Since the start of this condition, describe your current treatment. (e.g. medications, procedures, etc.) _____

b) Describe how your condition has changed since starting treatment. _____

13) OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

Have you applied for or are you receiving any of the following? If so, please complete the following chart.

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

2. Have you had a prior absence from work due to any illness or injury lasting longer than 60 days in the last 2 years? ❑ Yes ❑ No If "Yes",

Date Disability Began (DD/MM/YY) _____ Date Disability Ended (DD/MM/YY) _____

Was a disability claim filed? ❑ Yes ❑ No Please Provide Details: _____

3. Under what Desjardins Financial Security other policies are you currently covered? For example, Life Insurance.

Policy Type _____ Policy Number _____

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

14) EDUCATION AND WORK HISTORY

1. a) Please circle the highest grade that you have completed: 1 2 3 4 5 6 7 8 9 10 11 12 13

   b) Have you attended a technical or trade school? ❑ Apprenticeship Program or ❑ College / University

   Name of Course/Program _____ Diploma/Degree Obtained _____

   c) Have you taken a Business or Commercial Course? ❑ Yes ❑ No Please list courses taken:

   _____ Completed: ❑ Yes ❑ No

   _____ Completed: ❑ Yes ❑ No

   _____ Completed: ❑ Yes ❑ No

   d) Please describe other educational training or skills upgrading (including on-the-job training, special interest courses, etc.). In addition, list any other skills you have acquired. These skills may include typing, computer skills, operation of equipment, supervisory skills, special licenses, etc. They may also include skills acquired through volunteer work, hobbies and interests.

   _____

   _____

   _____

2. Driver's Licence. _____

3. Special Licence. _____

Chambers Plan
Employee Benefits

Long Term Disability – Owner's Statement

DECLARATION AND AUTHORIZATION

Your Chambers Plan disability benefits are underwritten by Desjardins Financial Security. All personal information that Desjardins Financial Security Life Assurance Company has or will have regarding you will be kept confidential in **a file opened for the purpose of offering you insurance, annuities, credit and other related financial services**. Access to your file will be restricted to employees of Desjardins Financial Security Life Assurance Company who must consult it in the course of their duties. You may access your file and ask that the information it contains be corrected, provided you can demonstrate that this information is inaccurate, incomplete, ambiguous, out-of-date or unnecessary. You may consult your file on written request to the person in charge of protection of personal information at Desjardins Financial Security Life Assurance Company, 200 avenue des Commandeurs, Lévis, Québec, G6V 6R2.

I certify that the information provided on this Claimant's Statement is true and correct.

I AUTHORIZE Desjardins Financial Security, strictly for the purpose of determining my insurability, managing my file and settling my claims to: a) collect from any natural person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, Chambers of Commerce plan administrator (Johnston Group Inc.), my employer or former employers; b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

This authorization will remain valid until my claim is completely resolved. A photocopy of this authorization, as executed by me, will be as valid as the original.

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

Name of Claimant (Please Print) _____

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

Name of Witness (Please Print) _____

APPLICATION FOR ELECTRONIC FUNDS TRANSFER

Please note that the designated account must be in your name or held jointly by you and another person(s). I hereby authorize Desjardins Financial Security to deposit my disability benefits into the bank account noted below.

Name of Bank _____

Bank No. _____ (3 digits) Transit No. _____ (5 digits) Account No. _____ (Variable number of digits)

Signature _____ Date (DD/MM/YY) _____

To ensure that your benefits are deposited into the correct account, please attach a sample cheque marked 'VOID". If this is not possible, your bank representative should assist you in completing account information. It is important that we are notified in advance if there is to be any change in your account (i.e. account number or place of banking).