Desjardins Insurance
LIFE • HEALTH • RETIREMENT

PO Box 4593 STN A
Toronto ON M5W 4X7

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.

Last name and first name of employee		Certificate or identification no.
Name of policyholder or employer	Policy no.	Division no.
Address of policyholder or employer - no., street, suite	City	Province / Postal code
Telephone no.: ( ) -	Fax no.: ( ) -	

COMPLETE IF SELF-ADMINISTERED: **Effective date of coverage:** YYYY MM DD **Class no.:**

B - GENERAL INFORMATION

1. Current salary
☐ Weekly ☐ Monthly ☐ Bi-monthly
$

2. Salary effective date
YYYY MM DD

3. Job status
☐ Full time ☐ Part time

4. Indicate days in normal work week
☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT

Hours worked per week

4.A
☐ Rotating schedule
☐ Variable schedule

5. Premium paid by:
☐ Employer
☐ Employee
☐ Both

6. Deductions:
☐ Weekly
☐ Bi-monthly
☐ Monthly

	Exemption Code	Tax Withheld at Source	CPP/QPP Contribution	EI Contribution (HRSDC)	Parental insur. (QPIP) Qc only
Federal					
Provincial					

7. Date of employment
YYYY MM DD

8. Occupation

9. Date last worked
YYYY MM DD

No. of hours worked

10. Did or will the employee receive any income during the disability period? ☐ Yes ☐ No **If "Yes"**, indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)

Type: **Amount:** **Period:**

11. If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CSST (Québec only)? ☐ Yes ☐ No

12. Has a claim been filed with a government agency? ☐ Yes ☐ No **If "Yes"**, indicate below:

☐ CSST/WCB/WSIB/WHSCC ☐ CPP/QPP ☐ SAAQ (Québec only) ☐ No Fault (outside Québec only)

☐ Other, specify: _____

YYYY MM DD

Date Filed: **Decision Rendered:** **Amount:**

13. Has the employee returned to work? ☐ Yes ☐ No **If "Yes"**, on what date?
YYYY MM DD

14. Is this person still in your employ?
YYYY MM DD
☐ Yes ☐ No **If "No"**, specify termination date: Reason:

15. Was this person given a record of employment? ☐ Yes ☐ No

16. Is there any reason why this claim should not be paid? ☐ Yes ☐ No Comments, if any

_____

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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 time **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
☐ Outside	☐	☐	☐
☐ In extremes of cold or heat	☐	☐	☐

FREQUENCY:	O	F	A
☐ In a damp or humid environment	☐	☐	☐
☐ Toxic fume	☐	☐	☐

FREQUENCY:	O	F	A
☐ Above or below ground level	☐	☐	☐
☐ Handling chemicals	☐	☐	☐

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
☐ Standing	☐	☐	☐
☐ Walking	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Keeping one's balance	☐	☐	☐

FREQUENCY:	O	F	A
☐ Bending over	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐

FREQUENCY:	O	F	A
☐ Extending/reaching above head	☐	☐	☐
☐ Climbing	☐	☐	☐
☐ Stairs (No. of steps _____)	☐	☐	☐
☐ Ladders (Height _____)	☐	☐	☐

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY: O	F	A	WEIGHT:
☐ Pushing _____	☐	☐	☐	☐ lb ☐ kg
☐ Pulling _____	☐	☐	☐	☐ lb ☐ kg
☐ Lifting/carrying _____	☐	☐	☐	☐ lb ☐ 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: _____

6. Are there any other potential work-related factors which may influence this employee's return to work? ☐ Yes ☐ No

If "Yes", please specify: _____

SIGNATURE OF THE AUTHORIZED PERSON

Last name and first name of the authorized person (in block letters) _____ Position _____

Signature _____ **Date** _____

PRINT NEW REQUEST