Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
Life • Health• Retirement

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.*

Address of employee - No., street, apt. | City | Province | Postal code

Telephone no.: ( ) - | E-mail address:

POLICYHOLDER OR EMPLOYER Name | Policy or group or contract no. | Division no.

PEBT | 64090S

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.:**

* 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 — Amount $
☐ Weekly ☐ Monthly ☐ Every two weeks

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

5 Type of schedule
☐ Variable ☐ Rotating

6 Premium paid by
☐ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD)

8 Occupation

9 Date last worked (YYYY MM DD) — No. of hours worked

10 Is disability due to an accident? ☐ Yes ☐ No **If "Yes"**, date of accident: (YYYY MM DD)

11 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:**

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

13 Has a claim been filed with a government agency? ☐ Yes ☐ No **If "Yes"**, indicate below:
☐ CNESST / WCB / WSIB / WHSCC ☐ CPP / QPP ☐ SAAQ (Québec only)
☐ Other, specify:
Date Filed: (YYYY MM DD) **Decision Rendered:** (YYYY MM DD) **Amount:** $

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

15 Is this person still in your employ? ☐ Yes ☐ No - Termination date: (YYYY MM DD) Reason:

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

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?
☐ No ☐ Yes - Please specify:

18 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.

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
☐ 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: _____

_____

_____

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**

SAVE | PRINT | NEW REQUEST