Desjardins Financial Security™

P.O. Box 4593 STN A
Toronto ON M5W 4X7

DISABILITY CLAIM

EMPLOYER'S STATEMENT

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

A - IDENTIFICATION – We are unable to assess this claim unless all questions are answered completely.

NAME AND ADDRESS OF EMPLOYEE		Date of Birth D M Y	Sex ☐ M ☐ F
			Social Insurance No.
	Postal Code	Home Telephone No. ( ) -	
NAME AND ADDRESS OF POLICYHOLDER OR EMPLOYER			Policy No.
			Division No.
	Postal Code	Telephone No. ( ) -	Fax No. ( ) -	Certificate or Identification No.

Complete if self-administered: **EFFECTIVE DATE OF COVERAGE:** D M Y | **Class No.:**

B - GENERAL INFORMATION

1. Current Salary	2. Salary Effective Date	3. Job Status	4. Indicate days in normal work week	Hours worked per week	5. Premiums paid by:
☐ Weekly ☐ Monthly		☐ Full time	☐ SUN ☐ MON ☐ TUE ☐ WED		☐ Employer ☐ Both
$	D M Y	☐ Part time	☐ THU ☐ FRI ☐ SAT		☐ Employee

6. ☐ Weekly ☐ Monthly Deductions

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

7. Date of Employment: D M Y

8. Occupation:

9. **Date last worked:** D M Y | **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: _____

Date Filed: D M Y | **Decision Rendered:** | **Amount:**

13. Has the employee returned to work? ☐ Yes ☐ No | **If "Yes"**, on what date? D M Y

14. Is this person still in your employ? ☐ Yes ☐ No
If "No", specify termination date: D M Y | 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

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	☐	☐	☐
☐ In a damp or humid environment	☐	☐	☐
☐ Toxic fumes	☐	☐	☐
☐ 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	☐	☐	☐
☐ Bending over	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐
☐ 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

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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

AUTHORIZED PERSON	NAME (IN BLOCK LETTERS)	POSITION	SIGNATURE	DATE

EMPLOYEE'S STATEMENT

A - GENERAL INFORMATION

1. Training

Level of education

Work experience

2. Is disability due to an accident? ☐ Yes ☐ No | **If "Yes"**, date of accident D M Y | Time ☐ AM ☐ PM | Type of accident ☐ Work-related ☐ Motor Vehicle ☐ Other

Indicate details (where, how and witnesses)

3. Did you receive prior treatment for the illness or injury causing the disability? ☐ Yes ☐ No
If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists.

4. Name, address and telephone number of physicians and specialists who have treated you during the disability.

5. Did you take out Desjardins Financial Security Loan Insurance at your caisse or credit union?
☐ Yes - Contract No. : ☐ No

6. If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association or through another employer or under an individual policy, give the following particulars:

Name of Insurer	Policy No.	Certificate No.	Date Benefits Commence	Benefit Period	Benefit Amount	Weekly/Monthly
						☐ W ☐ M
						☐ W ☐ M

COMMENTS:

I hereby certify that the above answers are full and true to the best of my knowledge and belief.

EMPLOYEE SIGNATURE **DATE**

B - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from the Company's various financial services (insurance, annuities, credit, etc.). This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may send information on its insurance products for retirees to those whose names appear on its client list. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

C - AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION – To be completed for each claim

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any 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, the policyholder, 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. I authorize Desjardins Financial Security Life Assurance Company to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

SIGNATURE OF EMPLOYEE **DATE** **CERTIFICATE OR IDENTIFICATION NO.**

VERY IMPORTANT	PLEASE HAVE THE DECLARATION OF THE ATTENDING PHYSICIAN - ORIGINAL REQUEST COMPLETED AND FORWARD COMPLETED FORMS TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY, DISABILITY CLAIMS