Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

SHORT TERM DISABILITY CLAIM FORM

Plan Member/Employee Section (Please complete in full and provide date and your signature)

Name (first, middle, last)	Telephone number	Date of birth (dd/mm/yyyy)	
Address (number, street and apartment)	City	Province	Postal code

Policy number	Certificate number	Claim number (if known)

Cause of disability	Date of disability (dd/mm/yyyy)	If you have returned to work, give date or expected return date (dd/mm/yyyy)

Is the disability a result of an accident? ☐ Yes ☐ No | If "yes", date (dd/mm/yyyy) and time ☐ a.m. ☐ p.m.

Give full details of the accident (How and where it happened and resulting injuries)

Location: ☐ Work _____
☐ Home _____
☐ Elsewhere _____

Has or will a claim be filed with the WSIB/WCB? ☐ Yes ☐ No

If "yes", claim number _____

Has this claim been approved? ☐ Yes ☐ No

Are you receiving or are you eligible for benefits from any other source such as other insurance, car insurance, pension, E.I.? ☐ Yes ☐ No

Date of Accident (dd/mm/yyyy) _____

Auto Insurance Company _____ Claim number _____

Contact persons name _____ Telephne number _____

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify that the information given on this form is true, correct and complete. For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada ("Equitable"), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize. For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health relevant to this claim, to give to Equitable full particulars of such information, including any prior medical history relevant to this claim and benefits. I transfer and assign to Equitable, and agree to pay and refund to Equitable those disability and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Worker's Compensation, and other insurance policies. A photocopy or electronic version of this acknowledgement shall be as valid as the original.

Date (dd/mm/yyyy) | Signature:

Accept this as authorization for Equitable Life Insurance Company of Canada to deposit Group claim payments directly into my bank account.

Bank's Name: _____

Bank's Address: _____

_____

Bank's Phone No.: ( ) _____ Bank's Account No.: _____
area code

Institution Code: _____ Branch Transit No.: _____

PLEASE ATTACH A VOID CHEQUE OR WE ARE UNABLE TO PROCESS YOUR REQUEST

Date _____ Insured's Signature _____

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SHORT TERM DISABILITY CLAIM FORM

1. Employer/Plan Administrator Section (Form should be completed within 7 days of disability. Do not wait until the Plan Member returns to work. Please complete the attached employee's job description form.)

Plan Member name (first, middle, last)	Group Policy number	Plan Member's Certificate/Social Insurance Number (Required for taxable benefits)

Date of hire (dd/mm/yyyy)	Occupation	Effective date of insurance (dd/mm/yyyy)	If terminated/laid off, give date (dd/mm/yyyy)

Date last worked ☐ Regular duties Date (dd/mm/yyyy) _____ ☐ Partime/modified Date (dd/mm/yyyy) _____

Date returned to work ☐ Regular duties Date (dd/mm/yyyy) _____ ☐ Partime/modified Date (dd/mm/yyyy) _____

For TPA and self-administered groups please indicate the amount of Short Term Disability coverage: $_____

Regular Gross Earnings per week (prior to disability) $ _____

Is disability due to occupational accident or sickness? ☐ Yes ☐ No

Deductions - section must be completed if your plan is Non-taxable (i.e. employee pays 100% of premiums)

Income Tax $ _____ C.P.P. $_____ E.I. $ _____

Pension Plan $_____ Net Earnings $_____

Has disability been reported to the WSIB/WCB? ☐ Yes ☐ No

Does Plan Member receive any pay or benefits while disabled? ☐ Yes ☐ No **If "yes", give details/comments in Comments section below**

Comments: Include (where applicable) reason claim has been delayed, whether Plan Member is on vacation, any dates he/she has worked since first disabled, or any other information which will assist the company in considering the claim.

Employer name	Telephone number	Fax number

Address (number, street and suite)

City	Province	Postal code

_____ _____ _____

Date (dd/mm/yyyy) Name and Title of Plan Administrator Signature of Plan Administrator

Plan administrator email

2. Employer job description (to be completed by employer)

Describe in detail what the job involves including shift work, weekends, supervisory responsibilities and whether job is dependent upon others or whether their job depends on this Employee.

Modified duties available

☐ Yes ☐ No

If you have a job description or PDA of the Employee's job, please submit a copy along with the completed form.
List all types of machines, tools, office equipment and other special equipment this Employee uses to do his/her job.

What functions are required or considered necessary to operate the equipment in a safe manner?

Describe the work environment with regards to presence of respiratory irritants, noise, humidity, heat, cold, hazards, etc.

PHYSICAL ACTIVITIES REQUIRED — TOTAL HOURS PERFORMED DAILY

Please mark off (x) in the applicable spaces below, those physical activities REQUIRED in this job.

	Less than 1	1 - 2	3 - 4	5 - 6	7 - 8
LIFTING					
Under 10 pounds					
10 - 20 pounds					
20 - 50 pounds					
Over 50 pounds					
CARRYING					
Under 10 pounds					
10 - 20 pounds					
20 - 50 pounds					
Over 50 pounds					
REACHING					
Above shoulder height					
At shoulder height					
Below shoulder height					

In the normal work day, how long would this Employee be in the following positions if he/she was doing his/her regular occupation?

Sitting _____ hours Pushing/Pulling _____ hours Standing _____ hours

Gripping _____ hours Walking _____ hours Pinching _____ hours

COGNITIVE

please check Yes or No in the applicable spaces below

Comprehension	☐ Yes ☐ No	Information processing	☐ Yes ☐ No
Visual perception	☐ Yes ☐ No	Memory	☐ Yes ☐ No
Attention	☐ Yes ☐ No	Other	☐ Yes ☐ No

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SHORT TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

1. Part 1 to be completed by patient.
2. Part 2 to be completed by physician.
3. Any charge for completing this form is the patient's responsibility.

1. Plan Member /Employee Information and Consent (to be completed by the patient)

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female

Telephone number (+ area code)		Cell Phone number (+ area code)	
Address (number, street and apartment)		City / Province	Postal code
Employer's Name		Policy number	Member Certificate #
Height	Weight	Date of Birth (dd/mm/yyyy)	
Last Date Worked (dd/mm/yyyy)		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy)	

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify that the information given on this form is true, correct and complete. For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada ("Equitable"), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize. For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health relevant to this claim, to give to Equitable full particulars of such information, including any prior medical history relevant to this claim and benefits. I transfer and assign to Equitable, and agree to pay and refund to Equitable those disability and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Worker's Compensation, and other insurance policies. A photocopy or electronic version of this acknowledgement shall be as valid as the original.

Date (dd/mm/yyyy) | Signature:

2. Attending physician's section (to be completed by the doctor)

Please complete to the best of your knowledge

Primary Diagnosis:

Secondary and/or Complications:

If childbirth - expected or actual delivery date (dd/mm/yyyy): ☐ Vaginal ☐ C-Section

Occupational Illness/injury ☐ Yes ☐ No If yes, date of event (dd/mm/yyyy):	Auto accident ☐ Yes ☐ No If yes, date of event (dd/mm/yyyy):

Date of first visit to you pertaining to this condition (dd/mm/yyyy):

Attending physician's section continued (to be completed by the doctor)

First date of work absence due to condition (dd/mm/yyyy):

Hospitalization Is/was patient ☐ hospitalized or had ☐ day surgery
Date of admittance (dd/mm/yyyy) Date of discharge (dd/mm/yyyy) Institution Name

If surgery was performed please provide date and description of surgery Date (dd/mm/yyyy)
Description:

Treatment (drug, dosage, physiotherapy, other):

Prognosis Please provide the prognosis for recovery:

Expected return date to regular duties **OR** modified/graduated duties. (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: (dd/mm/yyyy) | Treatment Provider:

Please describe the patient's symptoms including history, severity and frequency:

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other

Attending physician's section (continued)

Please attach copies of all relevant:
- test results/investigations
- consultation reports

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist	Specialty	Date of Visit

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations.

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

7. Notice to physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)

Certified Specialty

Address (Street, City, Province, Postal Code)

Telephone number (+ area code)	Physician's Stamp
Fax number (+ area code)	
Signature	
Date signed (dd/mm/yyyy)	