Equitable™
Head Office
One Westmount Road North
P. O. Box 1603 Stn. Waterloo, Waterloo, Ontario N2J 4C7
TF: 1 800 265 4556 **T:** 519 886 5210 **F:** 1 888 505 4373
equitable.ca

SHORT TERM DISABILITY CLAIM FORM FULL

Plan Member/Plan Sponsor Section (Please complete in full and provide date and your signature. Incomplete responses or missing information will cause delays in the assessment and handling of this file.)

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

Policy number	Certificate number	Claim number (if known)

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

Is this claim a result of an accident? ☐ Yes ☐ No | If "yes", date (mm/dd/year) Time ☐ a.m. ☐ p.m.

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

Location: ☐ Work _____
☐ Home _____
☐ Elsewhere _____

If the accident is work related, have you submitted a claim with the provincial workers compensation plan? ☐ No ☐ Yes If "yes", claim number _____

Has this claim been approved by the provincial workers compensation plan? ☐ Yes ☐ No

Have you applied or will be applying for or are in receipt of other benefits from any other source such as other insurance, income replacement benefits from an auto insurer, pension, employment insurance, other government benefits, other income? ☐ Yes ☐ No

Date of Accident (mm/dd/yyyy) _____
Name of Agency or
Auto Insurance Company _____ Claim number _____

Contact persons name _____

Telephone number _____ Fax Number _____

Please attach a copy of any correspondence received in regards to your motor vehicle accident.

If you want Equitable to use electronic mail in addition to phone and regular mail for the purpose of communicating with you and to provide you with information and documentation regarding your disability claim, please provide your e-mail address, and sign and date the consent below. There is no obligation for you to provide this consent. We can continue to communicate with by phone and regular mail.

I consent to Equitable using electronic mail to communicate with me and to provide me with information and documentation regarding my disability claim.

Email address: _____

Signature: _____ Date: _____

PLEASE NOTE: Equitable cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable is not responsible for any loss or damages you may incur if your information is intercepted and misused.

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 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), provincial 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:

SHORT TERM DISABILITY CLAIM FORM FULL

Accept this as authorization for Equitable 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 _____

Upload the signed and completed form via equitablehealth.ca using our secure Document Submission Tool located under the My Resources tab. You can also fax them to 1 888 505 4373 or mail them to:

Equitable
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7

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SHORT TERM DISABILITY CLAIM FORM FULL

1. Employer/Plan Administrator Section (Form should be completed within 7 days of disability. Do not wait until the Plan Member returns to work. A job description is required and can be provided in the following formats: Equitable Job description form (form 197) or Employer job description/ physical demands analysis. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Plan Member name (first, middle, last)		Group Policy number	Plan Member's Certificate/Social Insurance Number (Required for taxable benefits)
Date of hire (mm/dd/yyyy)	Occupation	Effective date of insurance (mm/dd/yyyy)	If terminated/laid off, give date (mm/dd/yyyy)

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

Date returned to work ☐ Regular duties Date (mm/dd/yyyy) _____ ☐ Part time/modified Date (mm/dd/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 $ _____
Employees last paid date (mm/dd/yyyy): _____

Has disability been reported to the provincial workers compensation plan?
☐ Yes ☐ No

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

Comments: (Please include any other information you feel is relevant to this claim.)

1. Was there any scheduled, pre-approved vacation or any time off paid/ unpaid? Please provide details.

2. If vacation days paid, please provide dates, and if it was accrued prior to last day worked.

3. Was the employee under a performance review prior to last day worked?

Plan Sponsor name	Telephone number	Fax number
Address (number, street and suite)		
City	Province	Postal code

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

Plan administrator email _____

2. Employer job description (This section is not required IF you will be attaching a detailed job description including physical and cognitive demands, environment and work schedule for this employee.)

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.

Are there any modified duties or a modified work schedule available?

☐ Yes ☐ No Comments:

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 their job.

Describe the essential duties of this job.

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 lbs/(0.5-4.5 kg)					
10 - 19 lbs/ (5.0-8.6 kg)					
20 - 50 lbs/ (9.5-22.7 kg)					
Over 50 lbs/ (22.8kg)					
CARRYING					
Under 10 lbs/(0.5-4.5 kg)					
10 - 19 lbs/ (5.0-8.6 kg)					
20 - 50 lbs/ (9.5-22.7 kg)					
Over 50 lbs/ (22.8kg)					
REACHING					
Above shoulder height					
At shoulder height					
Below shoulder height					
CLIMBING					

In the normal work day, how long would this Employee be in the following positions if they were doing their regular occupation?

Sitting _____ hours Pushing/Pulling _____ hours Standing _____ hours

Gripping _____ hours Walking _____ hours Pinching _____ hours

2. Employer job description (This section is not required IF you will be attaching a detailed job description including physical and cognitive demands, environment and work schedule for this employee.)

COGNITIVE DEMANDS

Please check Yes or No in the applicable spaces below

Comprehension	☐ Yes	☐ No	Information processing	☐ Yes	☐ No	focus	☐ Yes	☐ No
Visual perception	☐ Yes	☐ No	Memory	☐ Yes	☐ No	concentration	☐ Yes	☐ No
Attention	☐ Yes	☐ No	Other	☐ Yes	☐ No	social interaction	☐ Yes	☐ No

DRIVING REQUIREMENTS

Is this employee required to drive while at work?

Please describe average time spent driving, type of vehicle and the required licence.

Upload the signed and completed form via equitablehealth.ca using our secure Document Submission Tool located under the Quick Links section. You can also fax them to 1 888 505 4373 or mail them to:

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ATTENDING PHYSICIAN'S STATEMENT

To allow us to make an assessment of your patient's file, please answer all of the questions in full. Incomplete responses or missing information will cause delays in the assessment and handling of this file. Any charge for completing this form is the patient's responsibility.

1. Part 1 to be completed by patient.
2. Part 2 to be completed by physician.

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

Plan Member/Plan Sponsor Name (Last, First, Middle Initial)			
Telephone number (+ area code)		Cell Phone number (+ area code)	
Address (number, street and apartment)		City / Province / Postal code	
Plan Sponsor Name		Policy number	Member Certificate #
Height	Weight	Date of Birth (mm/dd/yyyy)	
Last Date Worked (mm/dd/yyyy)		Date Returned to Work or Expected Return to Work Date (mm/dd/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 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), provincial 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 (mm/dd/yyyy) Signature:

2. Attending physician's section (to be completed by the doctor) Please attach a copy of all relevant test results, investigations, consultation/clinical notes, hospital discharge reports.

Primary Diagnosis:

Secondary and/or Complications:

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

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

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

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

Initial date of consultation pertaining to this disability (mm/dd/yyyy):

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

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

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

Treatment: physiotherapist chiropractor massage referral to specialist
Name:_____ Referral date:_____

	Medication:	Medication:	Medication:	Medication:	Medication:	Medication:
Date Started (mm/dd/yyyy)						
Initial Dosage						
Initial Response						
Date of Last Dosage Change (mm/dd/yyyy)						
Current Dosage						
Response						
Side Effects						
Compliance						
Date Medication Discontinued (mm/dd/yyyy)						

Indicate your patients functional capacity below for each question by checking "R" for Restriction (what your patient should not do) or "L" for Limitation (what your patient is unable to do).

Lifting Under 10lbs (4.98 kg) R ☐ L ☐ 10-19 lbs (5.0-8.6 kg) R ☐ L ☐ 20-50 lbs (9.5-22.7 kg) R ☐ L ☐ Over 50 (22.8kg) R ☐ L ☐

Carrying Under 10lbs (4.98 kg) R ☐ L ☐ 10-19 lbs (5.0-8.6 kg) R ☐ L ☐ 20-50 lbs (9.5-22.7 kg) R ☐ L ☐ Over 50 (22.8kg) R ☐ L ☐

Reaching Above shoulder height R ☐ L ☐ At shoulder height R ☐ L ☐ Below shoulder height R ☐ L ☐

Sitting	hours	**Overhead Lifting**	hours
Standing	hours	**Pushing/Pulling**	hours
Walking	hours	**Gripping**	hours
Pinching	hours	**Keyboarding**	hours

Prognosis Please provide the prognosis for recovery and time line:

Attending physician's section (continued)

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

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

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

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other

Please indicate your patient's cognitive/ physical restrictions (what your patient should not do) and limitations (what your patient is unable to do)
Please indicate if they are permanent temporary

1. Have you discussed a return to work with your patient?

2. Can your patient participate in a gradual or modified return to work plan?

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

Competency

Do you believe your patient is competent to cash cheques and use proceeds? ☐ 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 (mm/dd/yyyy)	

Please retain a copy of this form for your records. Completed forms can be Faxed to 1 888 505 4373 OR by mail to (do not use staples):

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Group Disability Claims Department
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