Equitable Life of Canada®

Group Disability Claims Department
One Westmount Road North
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www.equitable.ca

GROUP LIFE INSURANCE WAIVER OF PREMIUM APPLICATION – EMPLOYEE INFORMATION

This form is to be completed by the employee. (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.)

Last name: _____ First name: _____

Date of birth: _____ (mm/dd/yyyy)

Address (number, street, and city: _____

Province: _____ Postal code: _____ Telephone number: _____

Group policy no.: _____ Certificate No.: _____

Date you were first unable to work due to this disability: _____

If you have returned to work, provide the date of return: _____

Diagnosis: _____

Name and address(es) of other physicians consulted: Dates consulted (mm/dd/yyyy):

If confined to hospital for this disability, provide:
Name and address of hospital(s): Dates of confinement (mm/dd/yyyy):

Has surgery been performed or is surgery planned? ☐ Yes ☐ No If 'Yes', (proposed) date(s) of surgery: _____ (mm/dd/yyyy)

Are you taking any medication?
☐ Yes ☐ No If 'Yes': Names Dosage and frequency

Are you now:
☐ Able to complete all activities of daily living ☐ Unable to go outside ☐ Confined to bed or wheelchair at home
☐ Confined to hospital or other medical institution ☐ Able to go outside only with help ☐ Able to go outside without help

Describe symptoms, limitations: _____

What is the highest level of education you have?
☐ Primary school ☐ University: # of years: _____
☐ Secondary school ☐ College: # of years: _____
☐ Other certifications, licenses, apprenticeships: _____

2. Job Description

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

List all types of machines, tools, office equipment computer programs with which you have experience and other special equipment you use to do your job.

How might your condition prevent you from returning to work?

Before you stopped working, did your condition cause you to change: ☐ Your job duties ☐ Your hours of work ☐ Your attendance

If yes, explain how your condition caused these changes and provide the dates the changes were made, if possible.

What is the status of your job? _____

Do you expect to return to work at your current/any job? ☐ Part-time ☐ Modified ☐ Regular Date expected to return: _____ mm/dd/yyyy

☐ Yes ☐ No (give details below)

Are you currently involved in any other type of employment? ☐ Yes ☐ No If 'Yes', please describe below.
i.e. part-time employment elsewhere, home based business or volunteer work.

Are you eligible for, have you applied for, or are you now receiving income benefits from:	Canada/Quebec Pension Plan	☐ Yes ☐ No
	☐ Retirement or ☐ Disability	☐ Yes ☐ No
	Provincial Workers Compensation Plan	☐ Yes ☐ No
	Employment Insurance Benefits	☐ Yes ☐ No
	Any Other Disability Income Benefits	☐ Yes ☐ No

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AUTHORIZATION AND 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/CNESST, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health, to give to Equitable full particulars of such information, including any prior medical history 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: _____ Employee/Member Signature: _____
mm/dd/yyyy

Upload the signed and completed form via www.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:

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