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GROUP LIFE INSURANCE WAIVER OF PREMIUM PLAN SPONSOR CLAIM FORM

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

1. Employer Information

Name: _____

Employee's last name: _____ Employee's first name _____

Group Policy No.:_____ Certificate No.: _____

Name of employer: _____

Employee's job title: _____ Length of time in this job: _____

Date of hire: _____

Other Job Positions Held at the Employer: _____

_____

Date last worked: _____ Date paid to: _____ Number of hours: _____

Date expected to return: _____ Date returned: _____

Employee's basic salary and payment frequency on date of disability: _____

☐ hourly ☐ weekly ☐ monthly ☐ annual

If the employee's salary varies or is based on commissions, please include the previous year's T4 slip for Revenue Canada. If this employee receives commissions and/or bonuses, please provide details (i.e. amounts, frequency, etc.)

Are you able to accomodate this employee with modified duties/hours: ☐ Yes ☐ No If 'Yes', please explain:

_____

_____

_____

_____

Do you have other positions this employee could be suited for? Please describe or attach job descriptions.

_____

_____

_____

_____

Indicate why employee stopped working: ☐ Illness ☐ Injury

☐ Layoff – Dates: From _____ to _____

☐ Leave of Absense – Dates: From _____ to _____

☐ Other (explain): _____

Present Status of employee: ☐ On disability leave ☐ Terminated ☐ On Pension/retired ☐ Other (explain): _____

Please attach one of the following: ☐ Job description including physical demands analysis ☐ Employer Job Description (form 197)

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Please indicate the time period (in months and years) necessary to master activities involved in this job and the general training usually required before such employment can be obtained.

Please outline any courses and/or on-the-job training completed by the employee:

Are you aware of the employee being involved in any other type of occupation prior to disability or during leave?
i.e. part time employment elsewhere, home based business or volunteer work.

Date: _____ Employer Name: _____

Authorized Name of Employer/Plan Administrator (please print): _____

Authorized Signature of Employer/Plan administrator: _____

Title: _____

Telephone no: _____ Fax no: _____

Email: _____

Upload the signed and completed form via www.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:

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

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