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 1.800.722.6615

GROUP LIFE INSURANCE WAIVER OF PREMIUM APPLICATION - EMPLOYEE FORM

This form is to be completed by the employee.
Incomplete responses or missing information will cause delays in the assessment and handling of this file.

ONGOING ELIGIBILITY REVIEW

Last Name: _____ First Name: _____

Group Policy No.: _____ Certificate No: _____ Date of Birth: _____

Street Address: _____ City _____ Province _____

Postal Code _____ Telephone Number _____

1. Are you still receiving disability benefits from your Long Term Disability provider? ☐ Yes ☐ No
   Forward to us copies of all communication you received from your LTD disability benefits provider.

2. If you answered "No" to question (1.) are you or will you be appealing the decision to terminate your Long Term Disability benefits? Please comment on when this appeal took place and whether you have received a response to date.

   _____

3. Have you experienced any changes in your condition since our last correspondence? ☐ Yes ☐ No (If "Yes", please explain)

   _____

4. Has there or will there be any changes in your address or telephone contact information? (If "Yes", please advise)

   _____

5. Do you expect to return to work in the future? ☐ Yes ☐ No (If "Yes", please explain)

   _____

6. Are you currently involved in any type of medical or vocational rehabilitation treatment? (e.g. volunteer work, trial return to work, etc.)
   ☐ Yes ☐ No (If "Yes", please describe below)

   _____

If you want Equitable Life 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 Life 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 Life 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 Life is not responsible for any loss or damages you may incur if your information is intercepted and misused.

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GROUP LIFE INSURANCE WAIVER OF PREMIUM APPLICATION

ONGOING ELIGIBILITY REVIEW

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/CNESST/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:

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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