Equitable™
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
equitable.ca

GROUP LIFE WAIVER OF PREMIUM ATTENDING PHYSICIAN STATEMENT

Part 1 of 2: To be completed by EMPLOYEE (please print)

Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Name _____ Policy Number _____

Address _____ Phone Number ( ) _____

1. During the past year, have you for any reason been confined to your home, hospital or other institution? ☐ Yes ☐ No
   If "Yes", please provide details including reason for confinement, names of institutions and dates.

   _____

2. What are your present activities?

3. During the past year, have you worked:
   a) at your usual occupation? ☐ Yes ☐ No b) at any other occupation? ☐ Yes ☐ No

   On what date did you commence this work? _____
   a) Number of hours worked per week _____
   b) Amount of weekly wages or salary received $ _____
   c) Please indicate dates: From _____ To _____

5. When do you expect to be able to work: a) at your usual occupation? _____
   b) any other occupation? _____

6. Give information below about any disability benefit you are receiving, or may receive, other than from Equitable®:
   (proof of income may be required)

Source	Source Name	Date Claims	Amount	Frequency	Date Income Paid From
Canada/Quebec Pension Plan ☐ Retirement or ☐ Disability benefits					
Provincial workers compensation plan					
Individual or Group Life Insurance Income					
Social Security Administration					
War Veteran's Disability Pension					
Income Replacement Benefits – Motor Vehicle Accident					
Other (i.e. Legal Settlement)					

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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:

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:

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

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GROUP LIFE WAIVER OF PREMIUM ATTENDING PHYSICIAN STATEMENT

Part 2 of 2: Attending Physician's Statement of Continuing Disability (or at the Insurer's option such other benefits as the Insurer may wish to state)

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.

Employee Name _____ Policy Number _____

1. Diagnosis
   a) Primary
   b) Secondary (if applicable)

2. Present Condition
   a) Please describe complications, recent surgery or new independent condition(s) which are contributing to the duration of disability. Include results of current X-rays, E.K.G. or any other special tests.

   b) Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

3. Cardiac (if applicable)

   a) Functional capacity: (Canadian Cardio-Vascular Society (CCS))

   ☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

   Please forward results of exercise stress tests, angiogram or other relevant documentation.

   Blood pressure (last visit)

Systolic	Diastolic

4. Progress
   Has patient: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed

5. Treatment
   a) Is patient following recommended treatment program? ☐ Yes ☐ No If "No", comment in Remarks.
   b) Date of latest treatment: (dd/mm/yyyy) _____
   c) Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify)
   d) Names of other treating physicians and specialties _____

6. Restrictions and Limitations:
   a) Please indicate your patient's physical and/or cognitive restrictions (what your patient should not do) and limitations (what your patient is unable to do) _____
   b) Is this patient a suitable candidate for some form of trial employment? ☐ Yes ☐ No

7. Have you completed other requests regarding your patient's current medical condition to other sources, eg. other insurers, Canada Pension Plan, provincial workers compensation plan etc?

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Remarks:

I hereby certify that the best of my knowledge the answers given above are full and true.

Physician's Names: *(please print)*_____ Speciality: _____

Address: _____ Phone No: _____

_____ Fax No: _____

Signature: _____ Date: (dd/mm/yyyy) _____

Fax this completed form, along with any other pertinent documentation to **1 888 505 4373**
or mail to **(do not use staples)**:

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