Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1604 Stn. Waterloo, Waterloo Ontario N2J 0A7
TF 1.800.265.4556 **T** 519.886.5210

SHORT TERM TO LONG TERM DISABILITY APPLICATION – EMPLOYEE

To be completed by the Employee when transitioning from Short Term to Long Term Disability

The purpose of this form is to enable us to assist in evaluating the possibility of providing you with rehabilitation assistance. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Policy Number: _____ Certificate No.: _____Claim Number:_____

Social Insurance Number (for taxable benefits only) _____

Employee's Name: _____ _____
(first) (last)

Height: _____ ☐ inch ☐ cm Weight:_____ ☐ lbs ☐ kg

Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Separated/Divorced ☐ Widowed

Number of dependent children whom you support: _____ List of children's age(s): _____

Address: _____ City: _____

Province: _____Postal Code:_____Telephone: _____

Are you paid commissions, bonuses, overtime, car allowance? ☐ Yes ☐ No If "yes", please describe and include the previous year's tax notice of assessment from Revenue Canada.

Since your last update, please describe if your condition has changed.

Please describe your ability to perform the required duties of your job.

Please describe the training required to perform your duties at this job (i.e. on the job training, apprenticeship, formal education, etc.):

List any special or vocational courses required including training time to perform your duties at this job:

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Total number of years you have been employed in this type of work with your current employer and previous employers:_____

Additional Training: ☐ On the job training ☐ Apprenticeship ☐ Work-Study Program

What education level have you completed: ☐ Elementary – Grades ☐ 1-6 ☐ 7 ☐ 8
☐ High School – Grade ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13
☐ College ☐ University ☐ Other (specify): _____

List below all degrees, diplomas, certificates, licenses, apprenticeships or other qualifications, you hold:

i) _____ iv) _____

ii) _____ v) _____

iii) _____ vi) _____

List below all other kinds of work you have done for at least one or more years including military service if any:

Employer and Job Title	Duties	Worked from	To

Do you expect to return to work? ☐ Part-time ☐ Modified ☐ Regular ☐ New job/Other work Date expected to Return: _____

☐ Yes ☐ No If "No", give details below.

Are you currently involved in any other type of employment or receiving compensation for performing work?
(eg. part-time employment elsewhere or home based business)

☐ Yes ☐ No If "Yes", please describe below.

MEDICAL INFORMATION

Please list all doctors or health care providers you have seen since your last update. (Please include all providers' contact information.)

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Has there been any decision or any payment (temporary, permanent, or lump sum) made on the claims you have filed?

☐ Yes ☐ No If "yes", provide details and copy of correspondence confirming benefit payment.

Please indicate if you are in receipt of OR will be applying for any of the following benefits.

SOURCE	SOURCE NAME	DATE CLAIMED/& STARTED	AMOUNT	FREQUENCY
Canada/Quebec Pension Plan ☐ Retirement or ☐ Disability benefits) ☐ No ☐ Yes →				
Provincial Workers Compensation Plan ☐ No ☐ Yes →				
Group Life Insurance Income ☐ No ☐ Yes →				
Other Retirement Income/ Social Security Administration ☐ No ☐ Yes →				
War Veteran's Disability Pension ☐ No ☐ Yes →				
Income Replacement benefits – Motor Vehicle Accident ☐ No ☐ Yes →				
Short Term Disability, Long Term Disability, Creditor Disability or other disability income through another group benefits plan. ☐ No ☐ Yes →				
Other ☐ No ☐ Yes →				

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. If you would prefer to submit your information by another means, please contact us at 1.800.265.4556.

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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), 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:

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