Equitable™
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SHORT TERM TO LONG TERM DISABILITY PLAN MEMBER CLAIM FORM

To be completed by the Plan Member when transitioning from Short Term to Long Term Disability with Equitable.
The purpose of this form is to enable us to evaluate your claim for Long Term Disability benefits after reaching the maximum Short Term Disability benefit period.

Policy Number:	Certificate Number:
Social Insurance Number (required for taxable benefits as a T4A will be issued):	
Plan Member Name:	
Number of dependent children whom you support:	List of children's age(s):

RETURN TO WORK PLANNING

When do you expect to return to work? (dd/mm/yyyy) _____

☐ Part-time ☐ Modified ☐ Regular ☐ New job/Other work ☐ Never

EDUCATION, TRAINING AND WORK HISTORY

Please complete the section below and/or attach a copy of your resume.

What is the highest education level you have completed?:

☐ Elementary
☐ 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:

Certification/Diploma/Degree /Designation/Apprenticeship	Name of Institution	Date obtained

Since the start of your Disability claim/last day worked, have you participated in any educational courses, training/retraining, or other work? If yes, please describe below:

_____

_____

List below all work you have done to date including military service, and any volunteer/unpaid work, if any:

Employer and Job Title	Duties	Worked from	To

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OTHER INCOME

Since your claimed date of disability/last day worked, have you received any income or do you expect to receive any income in the future?
☐ Yes ☐ No

If yes, provide details and attach a copy of all correspondence confirming the income amount and effective date. (e.g. Disability, Retirement, Workers Compensation, Employment Income, Severence, CPP, Employment Insurance, Income Replacement Benefits, Motor Vehicle Accident related benefits, Litigated settlement, other).

Details: _____

_____

_____

_____

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:

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 you 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. If you would prefer to submit your information by another means, please contact us at 1 800 265 4556.

Upload the signed and completed form via 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
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