REQUEST FOR DISABILITY BENEFITS

GROUP INSURANCE

IMPORTANT : AS SOON AS AN EMPLOYEE IS ABSENT FROM WORK AND IS ELIGIBLE FOR DISABILITY BENEFITS, OR QUALIFIES FOR WAIVER OF PREMIUM, PLEASE TRANSMIT THIS FORM TO THE INSURER IMMEDIATELY. ANY INITIAL REQUEST SHOULD INCLUDE AN EMPLOYER'S DECLARATION, EMPLOYEE'S DECLARATION AND ATTENDING PHYSICIAN'S STATEMENT DULY COMPLETED AND SIGNED.

SHORT TERM DISABILITY ☐
LONG TERM DISABILITY ☐
WAIVER OF PREMIUM ☐

EMPLOYER'S DECLARATION

GROUP	DIVISION	CLASS	**CERTIFICATE**

NAME OF EMPLOYEE	SURNAME	SOCIAL INSURANCE NUMBER

OCCUPATION
PLEASE INDICATE THE PRINCIPAL FUNCTIONS AND RESPONSABILITIES, AND ATTACH A COPY OF THE JOB DESCRIPTION, IF POSSIBLE.

_____

_____

DATE EMPLOYED (D M Y)	EMPLOYEE'S WEEKLY GROSS SALARY	SINCE WHAT DATE (D M Y)
	_____ $ REGULAR WEEK HOURS _____	

LAST DAY WORKED

FULL TIME DATE (D M Y)	HOUR	PART TIME DATE (D M Y)	HOUR
	_____ A.M. ☐ P.M. ☐		_____ A.M. ☐ P.M. ☐

DEDUCTIONS : ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER : _____

	EXEMPTION CODE	INCOME TAX WITHHELD	CONTRIBUTIONS QPP / CPP	UNEMPLOYMENT INSURANCE
FEDERAL				
PROVINCIAL				

HAS THE EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐ IF YES, INDICATE DATE (D M Y) _____

HAS THE EMPLOYEE RETURNED TO HIS REGULAR OCCUPATION FOR AT LEAST 20 HOURS A WEEK? YES ☐ NO ☐

IF NO, EXPLAIN : _____

IS THE DISABILITY DUE TO A WORK RELATED INJURY OR ILLNESS? YES ☐ NO ☐

HAS A DISABILITY CLAIM BEEN FILED WITH WORKERS' COMPENSATION BOARD? YES ☐ NO ☐

IF YES, HAS THE CLAIM BEEN ACCEPTED? YES ☐ NO ☐

IS THE CERTIFICATE TERMINATED? YES ☐ NO ☐ IF YES, SINCE WHAT DATE? (D M Y) _____

IN YOUR OPINION IS THIS REQUEST JUSTIFIED? YES ☐ NO ☐

IF NOT, EXPLAIN _____

DATE	NAME OF EMPLOYER

BY	TITLE