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 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

APPLICATION FOR LONG TERM DISABILITY & JOB PROFILE

(To be completed by the Disabled Employee)

The purpose of this form is to enable us to process your claim as quickly as possible and to assist us in evaluating the possibility of providing you with rehabilitation assistance, etc. Please complete these questions as accurately as you can.

Claimant's Name:		Gender: ☐ Male ☐ Female
Date of Birth:	Height:	Weight:
Marital Status: ☐ Single ☐ Married ☐ Common-law ☐ Separated/Divorced ☐ Widowed		
Number of dependent children whom you support:	List children's age(s):	
Street Address:	City:	
Province:	Postal Code:	Telephone: ( )

Group Policy No.:	Certificate No.:/Social Insurance Number (S.I.N. is required for taxable benefits)
Employer:	Claim Number (if known):
Exact Job Title:	Length of Time on this Job: / Length of Time with the Employer:

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

Please describe in chronological order the events leading up to your date of disability.

Was the disability caused from a work related condition or a work related injury? ☐ Yes ☐ No

Date of Injury/Loss	Location of accident (if applicable)	Date of first treatment & name of provider

Are you still disabled? ☐ Yes ☐ No If "no", indicate Date Returned to Work:

Did you return to regular duties or modified? Please describe:

Are you applying for or receiving benefits from WSIB/WCB? ☐ Yes ☐ No If "yes", indicate below:

Date application submitted:	Claim no:

Does your physician support this being a work related disability? ☐ Yes ☐ No If "no", please explain:

All WSIB/WCB correspondence enclosed? ☐ Yes ☐ No If "no", please explain:
(failure to enclose documentation may delay claim assessment)

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Describe in detail what your job involves including shift work, weekends, supervisory responsibilities and whether job is dependent upon others or whether their job depends on you.

List all types of machines, tools, office equipment and other special equipment you use to do your job.

How might your disability prevent you from performing any of your job duties or using any of the above mentioned equipment?

Is your work considered: ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy

What are the physical activities required in this job with regard to: sight, hearing, speech, lower extremities and upper & lower back/neck?

Describe the work environment with regards to: presence of respiratory irritants, noise, humidity, heat, cold, hazards, etc.

Please mark off (x) in the applicable spaces below, those physical activities REQUIRED in YOUR job.

	TOTAL HOURS PERFORMED DAILY				
Physical Activities Required	Less than 1	1 – 2	3 – 4	5 – 6	7 – 8
LIFTING Under 10 pounds					
10 - 20 pounds					
20 - 50 pounds					
Over 50 pounds					
CARRYING Under 10 pounds					
10 - 20 pounds					
20 - 50 pounds					
Over 50 pounds					
REACHING Above shoulder height					
At shoulder height					
Below shoulder height					

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In your normal workday, how long would you be in the following positions if you were doing your regular occupation?

Sitting	_____hours	Regular hours of work:
Standing	_____hours	Days of your Work Week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
Walking	_____hours	First Break: from to
TOTAL	_____hours	Meal Break: from to

Explain how your disability prevents you from being in any of these positions for the required number of hours each day/shift:

Before you stopped working, did your disability cause you to change: ☐ Your job or duties ☐ Your hours of work ☐ Your attendance
If yes, explain how your condition caused these changes and show the dates the changes were made.

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

Total number of years you have been employed in this type of work: _____

List any special or vocational courses required, including training time:

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

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

List all diplomas, certificates, licenses, journeyman cards, etc., 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:

Job Title	Duties	Worked from	To

Do you expect to return to work at this job?
☐ Yes ☐ No If "no", give details below.

☐ Part time ☐ Modified ☐ Regular

Date Expected to Return:

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Are you currently involved in any other type of employment? ☐ Yes ☐ No If "yes", please describe below.
i.e. part time employment elsewhere or home based business

ACTIVITIES OF DAILY LIVING

Has your physician told you to restrict your activities in any way? ☐ Yes ☐ No If "yes", indicate the physician and describe the specific restrictions on your activities.

Check any of the following which presently apply to you:

- ☐ Confined in a hospital bed or other medical institution
- ☐ Confined to bed or wheel chair at home
- ☐ Not confined to bed or wheel chair but unable to go outside
- ☐ Able to go outside only with the help of another person or device
- ☐ Able to go outside without help
- ☐ Unable to drive automobile: ☐ short distances ☐ long distances ☐ no valid license

Are your home duties, social activities or ability to care for your personal needs limited in any way? ☐ Yes ☐ No If "yes", describe how and why they are limited.

If this disability is a result of a motor vehicle accident, please provide the following:

Date of accident:

Auto Insurance Company:

Contact Person:

Address:	City	Province	Postal Code
Telephone: ( )	Claim No.:		

Were you hospitalized due to this disability/accident? ☐ Yes ☐ No If "yes", please provide the following:

Name of hospital or institution and dates of admission & discharge.

Please indicate who your primary physician or caregiver is.

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MEDICAL INFORMATION

List the first and last name, address and telephone number of your **Family Physician** who has your most current medical records.
Check here ☐ if you have no family physician.

Name:		Speciality:
Street Address:		
City:	Province:	Postal Code:
Telephone: ( )	How long have you attended this physician's office:	
Date first seen:	Date last seen:	How often do you see him/her?
Reasons for visits:		
Type of Treatment Received:		

Please indicate **all other physicians** you have attended in the **past 3 years**.

Name:		Speciality:
Street Address:		
City:	Province:	Postal Code:
Telephone: ( )		
Date first seen:	Date last seen:	How often do you see him/her?
Reasons for visits:		
Type of Treatment Received:		

Name:		Speciality:
Street Address:		
City:	Province:	Postal Code:
Telephone: ( )		
Date first seen:	Date last seen:	How often do you see him/her?
Reasons for visits:		
Type of Treatment Received:		

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Please indicate **all other physicians** you have attended in the **past 3 years**. (cont'd)

Name:		Speciality:
Street Address:		
City:	Province:	Postal Code:
Telephone: ( )		
Date first seen:	Date last seen:	How often do you see him/her?
Reasons for visits:		
Type of Treatment Received:		

OTHER HEALTH CARE PROVIDERS

Have you been seen by other agencies for this disability? ☐ Yes ☐ No → If "yes", complete the information requested below.
i.e. Dept. of Veteran Affairs, Vocational Rehabilitation, Welfare, Social Worker, Psychologist, Physiotherapist, Chiropractor, Masseuse)

Name the person or company that referred you:			
Reason for Referral:			
Name of Agency:			
Contact Person:			
Address:	City	Province	Postal Code
Telephone: ( )	Claim No.:		
Type of Treatment or Examination:			
Dates of visits:			

Name the person or company that referred you:			
Reason for referral:			
Name of Agency:			
Contact Person:			
Address:	City	Province	Postal Code
Telephone: ( )	Claim No.:		
Type of treatment or examination:			
Dates of visits:			

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Have you or do you intend to file claims for Disability Benefits under any:

Social Security:	Applied	☐ Yes	☐ No	Intend to Apply	☐ Yes	☐ No
Canada/Quebec Pension Plan:	Applied	☐ Yes	☐ No	Intend to Apply	☐ Yes	☐ No
Employment Insurance Canada:	Applied	☐ Yes	☐ No	Intend to Apply	☐ Yes	☐ No

Has there been any decision or any payment (temporary, permanent, WSIB/WCB, or lump sum) made on the claims filed? ☐ Yes ☐ No →
If "yes", provide details and copy of correspondence confirming benefit payment.

Please indicate your entitlement to Disability Benefits or waiver of payments from these sources as a result of your disability.

SOURCE	SOURCE NAME	DATE CLAIMED/ & STARTED	AMOUNT	FREQUENCY
Canada/Quebec Pension Plan				
WSIB/WCB				
Group Life Insurance Income				
Retirement Income/ Social Security Administration				
War Veteran's Disability Pension				
Car Insurance Income				
Other				

AUTHORIZATION AND 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/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, to give to Equitable full particulars of such information, including any prior medical history 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.

Employee's/Member's Signature_____ Date_____

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You must notify The Equitable Life Insurance Company of Canada promptly if:

a. Your medical condition improves so that you would be able to work, even though you have not yet returned to work.
b. You go to work whether as an employee or as a self-employed person.
c. You apply for benefits under any WSIB/Workers' Compensation Board Law or Plan.
d. You apply for benefits under Canada/Quebec Pension Plan.
e. You apply for Retirement Benefits.
f. You are discharged from the hospital if you are now hospitalized.
g. You received increases in existing WSIB/WCB/War Veteran's Disability Pension.

Please keep a copy of this form for your records. **Please do not use staples.** Send this completed form, along with any other pertinent documentation, to:

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Alternatively, you can **scan** and **email** the forms to 'group-disability-claims@equitable.ca'.
Or **fax** your documents to 519.883.7406 or fax toll free to 1.888.505.4373

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