DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Rhyan James
Employee's (Claimant Name)

TO Desjardins Financial

RE RELEASE OF CONFIDENTIAL/PERSONAL INFORMATION TO JG Benefits Inc./CINUP (hereinafter "Policyholder")

INDIVIDUAL POLICY NUMBER : Select Policy Number

I hereby direct and authorize the company to discuss with the Policyholder (JG Benefits Inc./CINUP) any and all information or documentation concerning my claim and its evaluation by the company, including but not limited to, any medical, financial, vocational, rehabilitation, or any other confidential/personal information or documentation concerning my claim. I also authorize the Company (Desjardins Financial) to send to the policyholder, copies of correspondence the Company receives from me concerning my claim as well as any medical information received from external sources.

Duration and Revocation

I understand that

- It is not a requirement of the Policy/Policies that I authorize the company to disclose information to the Policyholder
- This authorization will remain valid for as long as I am claiming benefits or service from the Company: and,
- I am free to revoke this authorization at any time by sending written notice to the Company of such revocation.

I have read and understand the above. I am signing this voluntarily, and not under compulsion by anyone.

Rhyan James
Signature of Claimant

7-11-2022
Date

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Contact us: 1-800-263-1810 (toll free) or 416-926-2990

Desjardins
Insurance
Life · Health · Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYEE STATEMENT

The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked «VOID».

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee			Sex	Date of birth (YYYY MM DD)
James, Rhyan			☑ M ☐ F	1988 03 12
Address - No., street, apt		**City**	**Province**	**Postal code**
410 James Ave		Timmins	ON	P4N 5T2
Policy or group or contract no.	**Division no.**	**Certificate or identification no.**	**Social insurance no.**[1]	
641028			544 250 350	

Telephone no. (mandatory): (705) 272-8214

☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]: rhyanjdjames@gmail.com

[1] Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
[2] Please provide this information only if you authorize Desjardins Insurance to email you.

B - GENERAL INFORMATION

1 Training

Level of education: College / uni

Work experience:

Spoken language: ☑ English ☑ French Written language: ☑ English ☒ French

2 Is disability due to an accident? ☐ Yes ☑ No

If "Yes", date of accident: YYYY MM DD

Time ☐ AM ☐ PM

Type of accident ☐ Work-related ☐ Motor vehicle ☐ Other

Indicate details (where, how):

3 Did you receive prior treatment for the illness or injury causing the disability? ☒ Yes ☑ No

If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists:

4 Name, address and telephone number of physicians and specialists who have treated you during the disability:

Dr Ross Cochrane Family Health Team. 705-272-4200
275 Eighth St, Cochrane ON P0L 1C0

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

B - GENERAL INFORMATION (CONTINUED)

5 If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Start date of benefits (YYYY MM DD)	End date of benefits (YYYY MM DD)	Benefit amount	Weekly/Monthly
			YYYY MM DD	YYYY MM DD	$	☐ W ☐ M
			YYYY MM DD	YYYY MM DD	$	☐ W ☐ M

Comments:

C - DIRECT DEPOSIT ENROLMENT

Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution	Institution no.	Transit/branch no.	Account no.
Scotia bank	002	11072	0180289
Address - No., street, suite	**City**	**Province**	**Postal code**
1 Pine St S PO BOX 240	Timmins	ON	P4N 7C9

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on 7-11-2022. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: [signature] Date: 7-11-2022

D - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I hereby certify that the above answers are full and true. I authorize Desjardins Insurance strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Signature of employee: [signature] Date: 7-11-2022

VERY IMPORTANT

Please have the Initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
James, Rhyan	641028		1988 03 12.

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. **Diagnosis (including complications) - If psychiatric, give DSM-IV code.**

1.1 Primary: Diabetes diagnosis causing an unstable refraction

1.2 Secondary: Retinal side effects appears to have lipaemia retinalis

1.3 Subjective symptoms (including severity, frequency, duration): 4D fluctuation in refractive correction patient noticing fluctuations in vision - current glasses not working

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):

1.5 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☒ Severe ☐ With psychotic elements

2. **History**

2.1 Date symptoms first appeared or accident happened: 2022 10 27

2.2 Date patient's condition first prevented them from working: 2022 10 27

2.3 Has this patient ever had same or similar condition? ☐ Yes ☒ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment:

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☒ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☒ Unknown

2.6 If patient is pregnant, give E.D.C.:

2.7 Names and specialties of other treating physicians: MD Dr. Ross, waiting for a consult with Dr. Hurley (retinal specialist)

2.8 Current height: Current weight: Weight loss/gain to date:

3. **Treatment dates**

3.1 Date of first visit for current condition: 2022 10 27

3.2 Date of latest visit: 2022 11 03

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify):

3.4 Date of in-patient admission: YYYY MM DD

3.5 Date of discharge: YYYY MM DD

3.6 Date of out-patient treatment: YYYY MM DD

3.7 Name of hospital:

4. **Nature of treatment**

4.1 Medications (dose, frequency, date prescribed): MD to fill out

4.2 Surgeries (including dates): None

4.3 Other (including frequency):

4.4 Is patient following recommended treatment program? ☒ Yes ☐ No (please elaborate): I believe he is following the Treatment plan

5. Progress

5.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☒ Retrogressed

5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			< 1	< 1-2	< 2-4	4-6	6-8	< 1	< 1-2	< 2-4	4-6	6-8
6.1	Stand	☒ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☒ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☐ Yes ☒ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☒ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
6.7	☐ No restriction	☐ Repetitively: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N)
Drive: N Bend: N/A Squat: N/A Kneel: N/A Climb: Reach (above shoulders): Reach (below shoulder):

7. Psychiatric illness (if applicable)

7.1 History:

7.2 Precipitating chronological events:

7.3 Work issue related to this illness:

7.4 Pre-morbid personality:

7.5 Changes in ADL habits:

7.6 Familial risk factors:

7.7 Progress with treatment plan:

7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☐ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility:

7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when:

8. Return to work plans

8.1 Prognosis for improvement or recovery: Patient needs to manage diabetes + vision will return to normal.

8.2 Expected date patient will return to their own occupation:

8.3 If unknown, please indicate the next follow up date: 2022 11 29.

8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: one medication + diet balanced, vision will return + OK to work.

8.5 Have return to work time lines been discussed with the patient? ☒ Yes ☐ No

8.6 Please elaborate on time frames and patient's response: 6 weeks.

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No
If yes, please specify:

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify:

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): Briand Karine
11.2 Specialty: Optometrist
License no.: 10048

11.3 Address - No., street, suite: 108 Pine St S
City: Timmins
Province: ON
Postal code: P4N 2K2

11.4 Telephone no.: (705) 262 - 1624
Fax no.: (705) 267 - 7703

Signature of physician: [signature]
Date: NOV 4, 2022