





1-844-409-6571 (toll free)

Keep original forms for your records.

GROUP INSURANCE - DISABILITY CLAIMS



DISABILITY OR WAIVER OF PREMIUM CLAIM

EMPLOYER STATEMENT

MPLOYEE Last name and first name	Certifica	ate or identification no	. Social	insurance no.*
Martyn Kristy		0063483387		513-151-563
ddress of employee - No., street, apt.	City	F	Province	Postal code
629 Park Row	Thunder Bay, Ontai	rio (NC	P7C 1N4
elephone no.: (807) 4 7 3 = 3 5 7 2	E-mail a	address:	kmartyn@nar	legal.on.ca
OLICYHOLDER OR EMPLOYER Name	Policy o	r group or contract no	o. Division	n no.
INUP		641028		
ddress of policyholder or employer - No., street, suite	City		Province	Postal code
01 Syndicate Ave N	Thunder Bay	(NC	P7E5R6
elephone no.: (807) 6 3 3 - 1 4 1 3	Fax no.: () MM DD	-	
OMPLETE IF SELF-ADMINISTERED: Effective date of covera		WIM DD	Class no.:	
Social insurance number is necessary only if the disability claims a	are taxable.			
I/Ula lava Cia and and la	W			
- GENERAL INFORMATION If the benefits are taxable, in all other cases, please places.				
Current salary Amount		effective date	3 Job status	
Weekly	40 2 0 2	MM DD	Full tim	e Part time
Indicate days in normal work week Hours worked 5	Type of schedule		n paid by	
SUN ☑ MON ☑ TUE ☑ WED per week	-		alawar DE	mployee Both
☑ THU ☑ FRI ☐ SAT 35.00	✓ Variable Rota		·	
Date of employment OD Occupation		9 Date last work	ked MM DD	No. of hours worked
2 0 2 2 - 1 1 - 3 0 MJBH Facilitator		2 0 2 4 -	0 7 - 0 5	7.00
Is disability due to an accident?	If "Yes", date of accide	ent:	MM DD	
Did or will the employee receive any income during the disability	period? ✓ Yes	No If "Yes"	, indicate below:	
(Type: holiday pay, maternity, disability, El benefits, salary, lump s		NO II fes	, indicate below.	
Type: Sick Pay	Amount: \$	1,124.00 Peri	od: July 8 - 12	
If the employee is pregnant, has an application for a preventive will			NESST (Québec	only)? Yes
		2× × × 2 0	12001 (440000	51,7.
Has a claim been filed with a government agency?	✓ No If "Yes", ind	licate below:		
CNESST/WCB/WSIB/WHSCC CPP/QPP	SAAQ (Québec or	nly)		
Other, specify:				
Date Filed:	Decision Rendered:		Amo	unt: \$
Has the employee returned to work? ☐ Yes ✓ No	f "Yes", on what date?	YYYY MM	DD	
Is this person still in your employ? Yes No - Termin	ation date:	MM DD R	Reason:	
	✓ No			
Was this person given a record of employment?		or had an impact on	their return-to-we	ork?
Was this person given a record of employment? Yes Are there any work-related factors that may have contributed to t	he employee's disability	o		
State of the state	he employee's disability			

C.	C - PHYSICAL WORK ENVIRONMENT Please attach a brief job description if a	vailable.			
1	1 What are the main duties of the employee's job and how much time is allocated to eac				
	Paries 70 Paries	Aftercare work with	youth -ages 12-29		%
	Duties See attached job description % Duties			Î	%
	For questions 2 and 3, FREQUENCY is d	lefined as follows			
	OCCASIONALLY: 0-15 % of the times FREQUENTLY: 16-50 % of	the time A	LWAYS: 51 % + of	the time	
2	2 Work environment - Does the employee's job require work in any of the following condi	itions?			
	FREQUENCY: O F A FREQUENCY:	OFA	FREQUENCY:	0 F	Α
	Outside		Above or below grou	ınd level	
	☐ In extremes of cold or heat ☐ ☐ ☐ ☐ Toxic fume		Handling chemicals		
	Does the job involve other hazards? Yes Vo If "Yes", please lie	st:			
					_
					_
3	3 Check the items below that relate to the employee's job, and complete the information	requested.			
	FREQUENCY: O F A	FREQUEN		0 F	<u>A</u>
	☐ Standing ✓ ☐ ☐ Bending over ☐ ☐ ☐ Walking ✓ ☐ ☐ Kneeling ☐ ☐	☐ Extending	g/reaching above hea	ad 📙 📙 L	\exists
	☐ Sitting ☐ ☐ Crouching ☐ ☐ ☐	☐ Stairs	(No. of steps		ቯ
	☐ Keeping one's balance ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		ers (Height		
	DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	F	REQUENCY: O F		_
	Pushing				_
	Pulling				Kg
	Lifting/carrying				Kg
	Please list any office equipment, motor vehicle, tools or other equipment that is used in		b.	•	
	10 September 2000 Control Cont				
	Type of equipment Computer-laptop, cell phone, motor vehicle	Т	imes per day	All Day/as required	
	Type of equipment Computer-laptop, cell phone, motor vehicle	Т	imes per day	All Day/as required	_
	Type of equipment Computer-laptop, cell phone, motor vehicle Type of equipment	1	imes per day	All Day/as required All day	
4		Т	imes per day	All day	
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Nishnawbe-Aski Legal Services Corporation

TALKING TOGETHER PROGRAM FACILITATOR

Job Description

Title: Aftercare Worker Dept.: My Journey Back Home

Reports to: TTP Manager **JD #:**

Approved: REVIEWED:

Summary

'My Journey Back Home' project is funded by the Ministry of CCSS. The purpose of the project is to utilize a traditional/alternative justice approach to assist youth facing crisis, violence, human-trafficking, homelessness, drug addiction, mental health, lack of education, legal issues, lack of life skills, basic needs and who have lost their path in their life cycle journey. The process used is the Circle in order to empower youth to arrive at acceptable resolutions. Circles are arranged and conducted by a Facilitator.

Core Competencies:

- Ability to speak the language and knowledge of culture an asset
- Experience and knowledge of the legal system is an asset. Ability to engage people to build trust and rapport; effective verbal and listening communication skills specifically in conflict resolution and nonviolent crisis intervention; excellent interviewing and counselling skills
- Excellent case and file management skills, administrative and coordination skills, stress management and time management skills, ability to meet deadlines
- Proficient working knowledge of MS Office Software, internet, and general office equipment
- Offer crisis intervention and de-escalation for people who have multiple and complex needs, including homelessness, lack of access to services/supports, ill-health, mental illness, substance misuse, trauma and violence, discrimination, cognitive impairment, etc.
- knowledge of the resources in the community for individuals, youth and families who are homeless, at risk of homelessness, living in poverty, or living with mental health or addiction issues · ability to integrate harm reduction approaches as appropriate in interactions with the client

Job Duties

The duties, responsibilities and obligations of the Aftercare Worker are the following:

- To contribute to the evaluation process under the direction of the Talking Together Manager;
- To liaise with the community initially to determine needs and wishes and educate them about the process and on an ongoing basis to keep them informed about the project;
- To provide follow up to ensure that the agreements are adhered to
- To liaise with Elders, frontline workers and Chief and Council as needed to garner support for the project and individual Talking Together Circles;
- Focus on early intervention/diversion
- Meet with clients and assist them in setting realistic personal goals
- Maintain regular follow-up with each client to achieve their goals
- Make appropriate referrals to other services, both in-house and to partner agencies in the community, as necessary
- Complete concise and accurate case notes and files on each client
- Meet with Program Manager for regular supervision and engage in formal evaluation meetings
- Report on the progress of clients as required;
- To prepare and submit weekly, monthly and quarterly reports in a timely manner;
- To pursue an integration of services with other NALSC programs and staff;
- To consult with NALSC staff lawyers or the Talking Together Manager as needed for issues requiring legal advice or direction
- Proactive community outreach including building partnerships with fellow service providers.
- Advocates on behalf of clients to address barriers to service;
- Maintains database and client management files to track client referral and follow-up information.
- Gather information from assessments and client meetings to identify barriers to housing;
 develop and implement a client care plan outlining goals and steps taken to achieve them
- Help clients to identify goals, continually monitor and evaluate these goals,
- Independently provide ongoing case management with clients; conducting check-ins with clients as seen appropriate
- Collaborate with community service agencies to establish support plans for the client
- Conduct referrals and coordinate with relevant community supports engaged in the client's care plan; assisting the client to identify and obtain resources and supports
- Advocate on behalf of the client and provide residents with tools that may allow them to do so on their own, assist clients to navigate health, social, and legal fields

Requirements

- This position requires at a minimum a secondary school diploma with related work experience.
- It is preferred that the Aftercare Worker hold a post-secondary degree or diploma in social work, child and family worker program, mental health or related fields

Reporting

 The 'My Journey Back Home' Aftercare Worker is responsible to the Talking Together Manager for day-to-day activities and to the Executive Director for overall work performance. Candidate must adhere to confidentiality as outlined in the Corporation policy and protocols.

Meetings, Training and Outreach

- Attend all meetings, telephone and video conferences, committees, as directed.
- Attend professional development, training, workshops, education, as directed.
- Develop positive relationships with justice providers, defense counsel, police authorities, community leadership, duty counsel, crown attorneys, probation, parole and more. Keep program coordinator, supervisor, manager, or director apprised.

File maintenance

- Ensure all paper and electronic files are maintained up-to-date.
- Ensure all client information is kept confidential and that client files are up to date and complete
- Follow directives, guidelines, and policies for records management and file keeping policies.

Additional Duties and Responsibilities

- Complete all additional responsibilities and duties as assigned.
- Other duties as assigned.

SALARY RANGE

Pursuant to current wage grid.



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



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. OM DE 0921 MARTUNI Postal code 2139 PORK ROW Policy or group or contract no Divisio THUNDER BAD Social insurance no Certificate or identification no 59086 0063 483387 517 150 563 Mauthorize Desigrations Financial Security hereinafter Desigrations Insurance, to leave me voicemail about my disability claim. Telephone no. (mandatory): (807)621 - 4062 E-mail address 2: Kristy. martyn @ Yako. Ca

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 Work experience English French Spoken language English French Written language Time Type of accident 2 Is disability due to an accident? If "Yes" date of accident Work-related Motor vehicle Other Yes Indicate details (where how) 3 Did you receive prior treatment for the illness or injury causing the disability? If "Yes" give particulars including name, address and telephone number of all treating physicians and specialists On wastlist for 13 years for surgery surgery is the only troopment 4. Name, address and telephone number of physicians and specialists who have treated you during the disability Dr NANA JUMAN 807-699-0692 410-63 ALGOMA STN TNUNDER BAY ON P7A 426

PLEASE COMPLETE THE BACK OF THE FORM.

06329E01 (2018-11)

Desardins Insurance refers to Desjardins Financial Security Life Assurance Company

Sunder an elaboration of sections coverage through a union society creditor mortgage audo lodge or other association, through another employer. Have of insignificant policy prove the following particulars. Have of insignificant policy prove the following particulars. Find an elaboration policy provided the provided in the provided policy of the provided policy o	B - GENERAL INFORMATION (CONTINUED)			
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D-PERSONAL INFORMATION MANAGEMENT Despardins Insurance handles the personal information it has on you in a confidential manner. Despardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted soldle by Despardins Insurance employees who need to ose in the course of their work. Despardins insurance may compile anonymized personal information for statistical and informational purposes. Despardins 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 to useful. To do so you must send a written request to the following address Privacy Officer. Despardins Insurance, 200, rue des Commandeurs, Lévis, Quebec, G6V 6R2, Despardins Insurance may use the client is 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 Despardins Insurance. E-DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION To be completed for each claim Thereby certify that the above answers are full and true. I authorize Despardins Insurance strictly for the purposes of determining my insurability, managing my file and setting my claims to (a) collect from any person or legal entity, or from any public or paropublic 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 Mill (formerly known as Medical Information European insurance for investigation agances, the policyholder, my employer or to former employers (b) communicate to the said persons or organizations or investigation agances. The polic	the credit in question shall constitute an amount paid in accordance to	with this authorization		-
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	signature of employee:		Date: July	1/0907

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



By mail: PO Box 1703 STN A Toronto ON M5W 1G6 Send original forms and keep copies for your records



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



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INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

ART 2 - Attending physician's statement is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultative properties for our review. Please include or indicate reasons for not including the requested information. 1. Diagnosis (including complications) - If psychiatric, give DSM-IV code. Primary New York New York Primary New York New York	$1_{\mathcal{K}}$	T1 - Identification of patient Ime and first name (PLEASE PRINT) Policy or group or contract no 641028 Certificate or identification no 1978-09-21
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j.	Restrictions and limitations										
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3	Walk No restriction Walk on uneven surfaces Pyes No					8	8				Ē
	Walk on uneven surfaces					-					
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.6	This patient can lift/carry a maximum of kgs	0	5	9		18	23	27	32 70	36 80	90
.7	No restriction ☐ Repetitively how much?	0	00	20	30	40	50	60			
	Occasionally how much?			Ö							
8	Please indicate in the space provided if this patient is able to perform					nally (O), or No	t at all [N	v) v shoulde	NE	
	Drive = Bend = Squat = Kneel = Climb	r Re	ach (above	shoulder	1) +		кеас	in (belov	v shoulde	11) .	
7.	Psychiatric illness (if applicable)										
7.1	History										
1.2	Precipitating chronological events										
7.3	Work issue related to this illness										
7.4	Pre-morbid personality										
	Changes in ADL habits										
	Familial risk factors										
	Progress with treatment plan							-			
7.8	Are patient's symptoms related to drug or alcohol abuse? \(\text{Yes}\) if yes, is patient enrolled in a substance abuse program? \(\text{Yes}\)	□ No If	yes, state	acility _							_
7.9	Has your patient ever been enrolled in a substance abuse program?	Yes	No If yes	state wh	nen						
8.	Return to work plans										
8.1	Prognosis for improvement or recovery Full receive	ey									
8.2	Expected date patient will return to their own occupation	weeks	post.	que	Hive	ly					
8.3	If unknown, please indicate the next follow up date										
	If your patient is unable to return to their own occupation, please sp	ecify when and	under what	circumst	ances the	v could	return t	o modifi	ed duties	10	
	gradual return to work										
8.5	Have return to work time lines been discussed with the patient?	Pres [No								
8.6	Please elaborate on time frames and patient's response										
	Rehabilitation										
9.	is patient a suitable candidate for medical rehabilitation services? (i.e.	e cardiopulmon	ary program	n, speech	therapy.	etc)		Yes	PINO		
600											
600	If yes, please specify				NA						-
9 1	If yes, please specify Is penent a suitable candidate for vocation rehabilitation?	DINO II	yes, please	specify :						-	
9 1	If yes, please specify Is persent a suitable candidate for vocabon rehabilitation? Yes.	MNO H	yes, please	specify							-
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July 15, 2024

Hi Julian Helie,

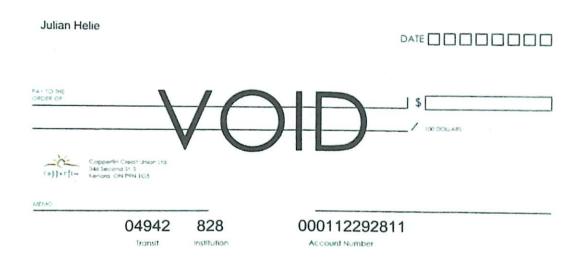
Re: Void Cheque

Please accept this copy of a void cheque as confirmation of your bank account information for the purposes of a pre-authorized debit or credit. Below are the details of your account:

Transit: 04942

Institution Number: 828

Account Number: 000112292811



Printed on July 15, 2024 from Copperfin Credit Union online banking for Julian Helie.

Thank you,

Copperfin Credit Union

Disclaimer: If your account number populates with an asterisk (*) in the form, please contact our Support Centre at 1-877-202-5722

Cascade Clinic

Dr. Naana Afua Jumah Pract #: 029930

Invoice Date: 2024-Jul-15

Invoice #: 46

410 - 63 Algoma Street

Thunder Bay ON, Canada P7A 4Z6

Phone: (807) 699-0692

INVOICE

Fax: (807) 622-5686

Att: Martyn, Kristy 2629 Park Row

Thunder Bay ON, Canada P7C 1N4

Re: Kristy Martyn 2629 Park Row

Thunder Bay ON, Canada P7C 1N4

Date of Service: 2024-Aug-09

Bill ID	Fee Code	ICD9 Code	Notes	Amount
1551	FORM	0	Form Completion	\$25 00

Payment History

Date Method Amount 2024-Jul-15 Payment(Cash) \$25.00

SubTotal \$25 00 HST \$0.00 Amount Paid \$25 00

Amount Due \$0.00

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM

TO

Desjardins Financial

RE

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

INDIVIDUAL POLICY NUMBER: Select Policy Number

641028

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 (Desiardins 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.

Signature of Claimant

July 11, 2024

Dear Amanda Ratte:

I would like to inform you that this is a notice of my resignation from my position in the role of Community Release and Reintegration Worker at Nishnawbe-Aski Legal Services Corporation in Pikangikum on August 23, 2024.

At the end of August, I am moving forward in life by starting a new life in the United States. I would like to say that during my time at Nishnawbe-Aski Legal Services Corporation, I have been fortunate for the opportunity to grow and learn more from everyone in the company. All the guidance and support I've received from the company will prepare me well for the future.

For now, I will continue to have the pleasure of working with you and the rest of the team until my last day.

Sincerely,

Mayor