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.

Desjardins Insurance
Life · Health · Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYER STATEMENT

A - IDENTIFICATION

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

EMPLOYEE Last name and first name		Certificate or identification no.	Social insurance no.*
Martyn	Kristy	0063483387	513-151-563

Address of employee - No., street, apt.	City	Province	Postal code
2629 Park Row	Thunder Bay, Ontario	ON	P7C 1N4

Telephone no.: (807) 4 7 3 - 3 5 7 2 E-mail address: kmartyn@nanlegal.on.ca

POLICYHOLDER OR EMPLOYER Name	Policy or group or contract no.	Division no.
CINUP	641028	

Address of policyholder or employer - No., street, suite	City	Province	Postal code
101 Syndicate Ave N	Thunder Bay	ON	P7E5R6

Telephone no.: (807) 6 3 3 - 1 4 1 3 Fax no.: ( ) -

COMPLETE IF SELF-ADMINISTERED: **Effective date of coverage:** (YYYY MM DD) **Class no.:**

* Social insurance number is necessary only if the disability claims are taxable.

B - GENERAL INFORMATION

If the benefits are taxable, the basic tax deductions will be made. In all other cases, please provide the appropriate tax forms.

1 Current salary — Amount: $ 2,248.40
☐ Weekly ☐ Monthly ☑ Every two weeks

2 Salary effective date (YYYY MM DD): 2022-11-30

3 Job status: ☑ Full time ☐ Part time

4 Indicate days in normal work week: ☐ SUN ☑ MON ☑ TUE ☑ WED ☑ THU ☑ FRI ☐ SAT
Hours worked per week: 35.00

5 Type of schedule: ☑ Variable ☐ Rotating

6 Premium paid by: ☑ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD): 2022-11-30

8 Occupation: MJBH Facilitator

9 Date last worked (YYYY MM DD): 2024-07-05
No. of hours worked: 7.00

10 Is disability due to an accident? ☐ Yes ☑ No **If "Yes"**, date of accident: (YYYY MM DD)

11 Did or will the employee receive any income during the disability period? ☑ Yes ☐ No **If "Yes"**, indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)
Type: Sick Pay **Amount:** $ 1,124.00 **Period:** July 8 - 12

12 If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (Québec only)? ☐ Yes ☐ No

13 Has a claim been filed with a government agency? ☐ Yes ☑ No **If "Yes"**, indicate below:
☐ CNESST / WCB / WSIB / WHSCC ☐ CPP / QPP ☐ SAAQ (Québec only)
☐ Other, specify:
Date Filed: (YYYY MM DD) **Decision Rendered:** (YYYY MM DD) **Amount:** $

14 Has the employee returned to work? ☐ Yes ☑ No **If "Yes"**, on what date? (YYYY MM DD)

15 Is this person still in your employ? ☑ Yes ☐ No - Termination date: (YYYY MM DD) Reason:

16 Was this person given a record of employment? ☐ Yes ☑ No

17 Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work?
☑ No ☐ Yes - Please specify:

18 Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☐ Yes ☑ No
If so, please indicate the percentage of employment income that is not taxable: %

PLEASE COMPLETE THE BACK OF THE FORM.

C - PHYSICAL WORK ENVIRONMENT

Please attach a brief job description if available.

1 What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties Aftercare work with youth -ages 12-29 | 100 % **Duties** Aftercare work with youth -ages 12-29 | %

Duties See attached job description | % **Duties** | %

For questions 2 and 3, FREQUENCY is defined as follows:

OCCASIONALLY: 0-15 % of the times **FREQUENTLY: 16-50 % of the time** **ALWAYS: 51 % + of the time**

2 Work environment - Does the employee's job require work in any of the following conditions?

FREQUENCY:	O	F	A
☐ Outside	☑	☐	☐
☐ In extremes of cold or heat	☐	☐	☐
☐ In a damp or humid environment	☐	☐	☐
☐ Toxic fume	☐	☐	☐
☐ Above or below ground level	☐	☐	☐
☐ Handling chemicals	☐	☐	☐

Does the job involve other hazards? ☐ Yes ☑ No **If "Yes"**, please list:

3 Check the items below that relate to the employee's job, and complete the information requested.

FREQUENCY:	O	F	A
☐ Standing	☑	☐	☐
☐ Walking	☑	☐	☐
☐ Sitting	☑	☐	☐
☐ Keeping one's balance	☐	☐	☐
☐ Bending over	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐
☐ Extending/reaching above head	☐	☐	☐
☐ Climbing	☐	☐	☐
☐ Stairs (No. of steps _____)	☐	☐	☐
☐ Ladders (Height _____)	☐	☐	☐

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY: O F A	WEIGHT:
☐ Pushing	☐ ☐ ☐	☐ Lb ☐ Kg
☐ Pulling	☐ ☐ ☐	☐ Lb ☐ Kg
☐ Lifting/carrying	☐ ☐ ☐	☐ Lb ☐ Kg

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment Computer-laptop, cell phone, motor vehicle | Times per day All Day/as required

Type of equipment | Times per day All day

4 Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? ☐ Yes ☑ No

If "Yes", please specify:

5 Does the employee's job require dexterity? ☑ Yes ☐ No

If "Yes", please specify: Reporting and writing updates and notes

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Colette Shwtez | Director of HR

Last name and first name of the authorized person (IN BLOCK LETTERS) | Position

cshwetz@nanlegal.on.ca

E-mail address

Signature **Date** July 17/24

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.

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)
MARTYN, KRISTY	☐ M ☑ F	1978 09 21

Address - No., street, apt.	City	Province	Postal code
2629 PARK ROW	THUNDER BAY	ON	P7C 4V3

Policy or group or contract no	Division no	Certificate or identification no.	Social insurance no [1]
641028	59086	0063483387	513 150 563

Telephone no. (mandatory): (807) 621 - 4062
☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address [2]: Kristy.martyn@yahoo.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

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

On waitlist for 15 years for surgery
Surgery is the only treatment

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

Dr. NDANA JUMAH
807-699-0672
410-63 ALGOMA ST N
THUNDER BAY ON
P7A 4Z6

PLEASE COMPLETE THE BACK OF THE FORM.

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
					$	☐ W ☐ M
					$	☐ 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
COPPERFIN CREDIT UNION	828	04942	0001122928 11

Address - No., street, suite	City	Province	Postal code
318 SYNDICATE AVE	THUNDER BAY	ONTARIO	P7C 1E3

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 _____ The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me

Signature of employee: [signature] **Date:** July 4/2024

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:** July 4/2024

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.

Desjardins Insurance
Life · Health · Retirement

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
MARTIN, KRISTY	641028	006348 3387	1978-09-21

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: Heavy menstrual bleeding

1.2 Secondary: Crohn's disease

1.3 Subjective symptoms (including severity, frequency, duration): 2 years

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: December 2022

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

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:

2.8 Current height: 175 cm Current weight: 152 lbs Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: 20/Sept/23

3.2 Date of latest visit: 5/Jul/24

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

3.4 Date of in patient admission: 5/Jul/24

3.5 Date of discharge: 5/Jul/24

3.6 Date of out patient treatment:

3.7 Name of hospital: Thunder Bay Regional Health Sciences Centre

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed):

4.2 Surgeries (including dates): Total laparoscopic hysterectomy and bilateral salpingectomy on 5/Jul/24

4.3 Other (including frequency):

4.4 Is patient following recommended treatment program? ☒ Yes ☐ No (please elaborate)

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 after 2 weeks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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 F Bend F Squat F Kneel F Climb F Reach (above shoulders) F Reach (below shoulder) F

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: Full recovery
8.2 Expected date patient will return to their own occupation: 6 weeks post-operatively
8.3 If unknown, please indicate the next follow up date: _____
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: _____
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: _____

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: NA

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): Dr Naana Jumah
11.2 Specialty: _____ License no: _____
11.3 Address: No., street, suite: 410 - 63 Algoma St North Province: _____ Postal code: _____
Thunder Bay ON P7A 4Z6
89225 / 029930-20
11.4 Telephone no: (807) 699-0042 Fax no: (807) 622-5286
Signature of physician: _____ Date: 12/Jul/24

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

Julian Helie

DATE ☐☐☐☐☐☐☐☐

PAY TO THE ORDER OF

VOID

$

100 DOLLARS

Copperfin Credit Union Ltd.
348 Second St. S
Kenora, ON P9N 1G5

MEMO

04942 Transit | 828 Institution | 000112292811 Account Number

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**
410 - 63 Algoma Street
Thunder Bay ON, Canada P7A 4Z6
Phone: (807) 699-0692
Fax: (807) 622-5686

Invoice Date: 2024-Jul-15
Invoice #: 46

INVOICE

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
41551	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

Thank you

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Kristy Martin
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
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 (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.

Kristy Martin
Signature of Claimant

July 4/2024
Date

Morningstar Quill Community Release and Reintegration Worker Pikangikum, ON P0V2L0
Nishnawbe-Aski Legal Services Corporation

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,