**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 | First name | Certificate or identification no. | Social insurance no.* |
|---|---|---|---|
| Okeese | Lena | 0063475551 | 497-667-899 |

| Address of employee - No., street, apt. | City | Province | Postal code |
|---|---|---|---|
| 59 Leach Road - Site 200 Comp 40 RR3 | Dryden | ON | P8N 3G2 |

Telephone no.: ( 807 ) 2 5 2 - 9 1 2 2 E-mail address: lokeese@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., Suite 101 | 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: $ 2,364.00
☐ Weekly ☐ Monthly ☑ Every two weeks

**2** Salary effective date (YYYY MM DD): 2022 - 10 - 21

**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 - 10 - 21

**8** Occupation: Restorative Justice Worker

**9** Date last worked (YYYY MM DD): 2024 - 03 - 15
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:** **Amount:** $ **Period:**

**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: 100.00 %

**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** | Processing Application | 75 % | **Duties** | | % |
| **Duties** | Court Travel on Flights | 25 % | **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 10) | ☐ | ☐ | ☐ |
| ☐ Ladders (Height ) | ☐ | ☐ | ☐ |

| DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT: | FREQUENCY: O | F | A | WEIGHT: |
|---|---|---|---|---|
| ☐ Pushing | ☐ | ☐ | ☐ | ☐ Lb ☐ Kg |
| ☐ Pulling | ☐ | ☐ | ☐ | ☐ Lb ☐ Kg |
| ☑ Lifting/carrying laptop bag | ☐ | ☐ | ☑ | 5 ☑ Lb ☐ Kg |

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

| | |
|---|---|
| Type of equipment Laptop Printer/Scanner | Times per day |
| Type of equipment | Times per 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: Phone calls and printing

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

**If "Yes"**, please specify: Mental awareness of dealing with clients and entering applications. Typing and written paperwork.

## D - ADDITIONAL INFORMATION

Driving to and from work. Occassional court flights when attendance is required.

## SIGNATURE OF THE AUTHORIZED PERSON

| | |
|---|---|
| Shwetz, Colette | Director of HR |
| Last name and first name of the authorized person (IN BLOCK LETTERS) | Position |
| cshwetz@nanlegal.on.ca | |
| E-mail address | |
| Colette Shwetz | Apr 12/24 |
| **Signature** | **Date** |

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Lena Okeese
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.

Lena Okeese
Signature of Claimant

April 11 | 24
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) |
|---|---|---|
| Okeese, Lena | ☐ M ☒ F | 1972 09 17 |

| Address - No., street, apt. | City | Province | Postal code |
|---|---|---|---|
| Site 200 Comp 40 RR3 | Dryden | ON | P8N 3G2 |

| Policy or group or contract no. | Division no. | Certificate or identification no. | Social insurance no.[1] |
|---|---|---|---|
| 641028 | | 0063475551 | 497 667 899 |

**Telephone no. (mandatory):** (807) 252-9122 ☐ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

**E-mail address[2]:**

[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:

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

**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 | End date of benefits | 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. |
|---|---|---|---|
| Address - No., street, suite | City | Province | Postal code |

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:** **Date:**

## 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:** April 11/24

**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.**

**Okeese, Lena Judy** 36418
Site 200 Comp 40 RR3 57 Leach Road
Dryden, ON P8N 3G2 F Sep 17, 1972
807-252-9122(H) 2878 131 354 YX

Inv # SV397761

VCC copy to Pt Chart @ DMG Apr. 10/24 KF

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

RECEIVED
APR 0 9 2024

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 |
|---|---|---|---|
| OKEESE, LENA. | 641028 | 006 347 5551 | 1972 09 17 |

## 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: Benign Paroxysmal Positional Vertigo.

1.2 Secondary:

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

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: 2024 04 03 (YYYY MM DD)

2.2 Date patient's condition first prevented them from working: (YYYY MM DD)

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.: (YYYY MM DD)

2.7 Names and specialties of other treating physicians:

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

**3. Treatment dates**

3.1 Date of first visit for current condition: 2024 04 03 (YYYY MM DD)

3.2 Date of latest visit: (YYYY MM DD)

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☒ Other (specify): 1 time in ER

3.4 Date of in-patient admission: NA (YYYY MM DD)

3.5 Date of discharge: 2024 04 04. (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): pm betahistine 16mg. Otolith repositioning maneuvers.

4.2 Surgeries (including dates): NA

4.3 Other (including frequency): NA

4.4 Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate): unknown - saw her once in the ER

## 5. Progress

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

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

## 6. Restrictions and limitations

Cannot drive or climb if wet/snowy - Another specific restrictions.

| | | 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: Bend: Squat: Kneel: 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: YYYY MM DD

## 8. Return to work plans

8.1 Prognosis for improvement or recovery: Excellent

8.2 Expected date patient will return to their own occupation: unknown

8.3 If unknown, please indicate the next follow up date: unknown - pt needs to book FU surgery.

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: _____

## 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. Stephen Viherjoki

11.2 Specialty: Family Medicine Licence no.: 88628

11.3 Address - No., street, suite: Dingwall Medical Group
Family Health Organization
P.O. Box 3011, 40 Goodall St.
Dryden, ON P8N 2Z6
City Province Postal code

11.4 Telephone no.: ( Phone: 807-223-6683 ext: 4011 Fax no.: ( ) -
Fax: 807-223-4733

Signature of physician: _____ Date: April 10/24

DH00079889 DA000218/24 2878131354-YX
OKEESE,LENA JUDY F 17/09/1972 51
807-252-9122 STEPHEN UTHERJOKI MD
03/04/24

Date April 4 24

This person has a medical condition that currently impairs her ability to drive + work safely. She can resume driving + work when her symptoms resolve

Dr.