Nishnawbe-Aski Legal Services
Corporation

ᐊᓂᔑᓇᐯ ᐊᐢᑭ ᑎᐸᑯᓂᑫᐧᐃ ᐧᐃᑭᐦᐃᐧᐃᑫᐧᐃᓇᐤ
ᒪᑭᒪᓱᐧᐃᐣ

Mailing Address:

86 S. Cumberland Street
Thunder Bay, Ontario
P7B 2V3

Tel: (807) 622-1413
Fax: (807) 622-3024

E-mail
info@nanlegal.on.ca

Website
www.nanlegal.on.ca

Head Office:

150 City Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1J7

FAX COVER SHEET

DATE: October 17, 2013 FAX NO.: (519) 434-3280

NAME: Joan Tanner

FIRM: GREAT WEST LIFE

CITY: London, Ontario

FROM: Kirsten Raserych.

MESSAGE: Short Term Disability claim for Stella Kiokee-Koostachin. Plan # 106790 (Employee's statement)

We are transmitting the following 7 pages (including this cover letter).
If you do not receive all the pages, please call back as soon as possible.

Telephone number: 807-622-1413
Fax number: 807-622-3024

CONTACT: _____

THE Great-West Life ASSURANCE COMPANY

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☒ Mrs. ☐ Ms.
   Your Name: First Stella Initial M Last Kiokee-Kpostachin
   Address: Street & Number
   P.O. Box 152
   City Attawapiskat Province ON Postal Code P0L1A0
   Telephone: Home (705) 997-2308 Work (705) 997-1285
   Cell (___) ___

2. Your GWL Employee Identification Number ___
   Your identification number must be completed. If unknown, please check with your employer.

3. Social Insurance Number 489 073 528
   If your employer pays for all or any part of your disability benefits coverage, any benefits payable may be subject to income tax. If this applies to you, please provide your Social Insurance Number for income tax reporting purposes. Your Social Insurance Number may also be used as an identification number where required in the administration of benefits.

4. Date of birth: Year 1966 Month 08 Day 12

Employer Information

1. Your Employer's Name: Nishnawbe Aski Legal Services
   Address: Street & Number 86 South Cumberland Street
   City Thunder Bay Province ON Postal Code P7B2V3
   Telephone Number: (807) 622-1413

2. Group Plan Number ___
   Plan number must be completed. If unknown, please check with your employer.

Claim Information

1. What is the nature of your condition? Carpal Tunnel
2. If disability is due to an accident, give date accident occurred: Year ___ Month ___ Day ___
   Where and how did it occur? ___
   Was the accident work-related? ☐ Yes ☐ No
3. From what date has your disability continuously prevented you from performing your regular work?
   Year ___ Month ___ Day ___
4. Have you performed any other work since that date? ☐ Yes ☐ No
   If yes, describe ___
5. Are you able to do any other work? ☐ Yes ☐ No
   If yes, describe ___
6. Please provide the name(s) and telephone number(s) of your attending physician(s).

MS454-2/13

Financial

1. Have you applied for, or are you receiving the following:

	I have Applied Yes	I have Applied No	I am Receiving Yes	I am Receiving No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☑	☐	☐	$ _____
Workers' Compensation Board Benefits (or similar plan)	☐	☑	☐	☐	$ _____
Employment Insurance Benefits	☐	☑	☐	☐	$ _____
Automobile Insurance Benefits	☐	☑	☐	☐	$ _____
Any other Disability Benefits	☐	☑	☐	☐	$ _____
Employer Sponsored Retirement / Pension Plan Income	☐	☑	☐	☐	$ _____
Self Employment Income or any other Employment Income			☐	☐	$ _____
Any other income	☐	☑	☐	☐	$ _____

For the duration of your claim for benefits, it is your responsibility to notify Great-West Life of:

- any work performed, whether or not you have received a wage or remuneration, or
- any employment income paid to you or any other person or party as a result of work performed by you.

2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes _____ Plan Number ☐ No

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

DIRECT DEPOSIT AUTHORIZATION

Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. All benefit payments covered under one plan number will be deposited into the same bank account.

☐ Savings Account, (please consult your bank for proper bank identification number.)

☑ Chequing Account, (please attach sample cheque marked "VOID")

PLEASE PRINT

NAME OF BANK, TRUST CO., CREDIT UNION, ETC.	TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (maximum 12 digits)
Scotiabank	11072		
BRANCH ADDRESS: 1 Pine Street S.	NAME IN WHICH ACCOUNT IS HELD: Edward & Stella Koostachin		
CITY OR TOWN & PROVINCE: Timmins, ON	POSTAL CODE: P4N 2J9		

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

Stella Koostachin
SIGNATURE OF EMPLOYEE

DATE

M5454-2/13

Protecting Your Personal Information

At The Great-West Life Assurance Company, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

Stella Kiokeetkoostachin — Signature

Print Name

Date

(705) 997-2308

Telephone Number

Canadian Life and Health Insurance Association Inc. / Association canadienne des compagnies d'assurances de personnes inc.

The patient is responsible for any fees related to the completion of this form.

THE Great-West Life ASSURANCE COMPANY

Attending Physician's Statement - Short Term Disability Claim

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)		
Employer's Name	Group Plan Number	GWL Employee Identification Number
Height / Weight	Date of Birth (dd/mm/yyyy)	
Last Date Worked (dd/mm/yyyy)	Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy)	

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature _____ Date of Consent (dd/mm/yyyy) _____

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.
For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: Rt Cubital Canal Tunnel Syndrome

Secondary and/or Complications:

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____ Vaginal ☐ C-Section ☐

Occupational Illness/Injury Yes ☐ No ☑	Auto Accident Yes ☐ No ☑
If yes, date of event. (dd/mm/yyyy)	If yes, date of event. (dd/mm/yyyy)
Date of first visit to you for/relating to this condition (dd/mm/yyyy) 16/10/2013	First date of work absence due to condition (dd/mm/yyyy) 16/10/2013.

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): 16/10/2013 Date of discharge (dd/mm/yyyy): 16/10/2013 Institution Name: Moore Factory Hosp

If surgery was performed please provide date and description of surgery.

Date (dd/mm/yyyy): 16/10/2013 Description: Release Median Nerve in left Carpal Tunnel

Treatment (drug, dosage, physiotherapy, other).

Prognosis. Please provide the prognosis for recovery: Expect full recovery in 6-8 weeks.

MS454-2/13

Canadian Life and Health Insurance Association Inc. | Association canadienne des compagnies d'assurances de personnes inc.

THE Great-West Life ASSURANCE COMPANY

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☑

If yes, date (dd/mm/yyyy): _____ Treatment Provider: _____

Please describe the patient's symptoms including history, severity and frequency.

Severe (L) Carpal tunnel Syndrome. Required surgical Release.

Frequency of Visits. ☐ Weekly ☑ Monthly ☐ Other _____

Please attach copies of all relevant:
test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
consultation reports

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

Name of Specialist: DR ANTHONY DAVEY Specialty: SURGEON Date of Visit: 26/9/2013.

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities.

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program? Yes ☑ No ☐

Prognosis Please provide the prognosis for recovery. (If not completed on page 1)

Expect full Recovery to (L) hand post surgery.

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
PETER DAVEY	SURGEON	
Address (Street, City, Province, Postal Code)		
MOOSE FACTORY HOSP. ONTARIO		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
705 658-4454		
Signature	Date Signed (dd/mm/yyyy)	
[signature]	16/10/2013.	

MS464-2/13

Weeneebayko General Hospital ᐧᐃᓀᐯᑯ ᐊᑦᔑᐧᐃᑲᒥᒃ

WEENEEBAYKO GENERAL HOSPITAL
A Division of Weeneebayko Health Ahtuskaywin
P.O. Box 34, Moose Factory, Ontario P0L 1W0
Tel.: 705-658-4544 Fax: 705-658-4452

STANDARD RETURN TO WORK/SCHOOL FORM

Patient's Name: Stella Kioke-Koostachin

This is to certify that the above patient was unable to work (attend school) due to illness/injury.

From: 16/10/2013 To: 27/11/2013

The patient was seen in the office on: 16/10/2013.

Comments:

Recovery from Surgery.

Signed: [signature] SURGEON

Date: 16/10/2013.

THE Great-West Life ASSURANCE COMPANY

Application for Group Short Term Disability Benefits - Employer's Statement

Great-West Life your Benefits Solutions People

Important:
The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed in their entirety and submitted to Great-West Life within 5 days of the onset of the disability.** Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee.

Ensure all sections and both pages are completed as lack of information will cause delays in claim assessment.

A. EMPLOYER IDENTIFICATION

Name	Plan Number	Division Number (if applicable)	Class (if applicable)
Nishnawbe Aski Legal Services Corp.	106790	1	
Address: Street & Number / P.O. Box	**City**	**Province**	**Postal code**
150 City Road	Thunder Bay	ON	P7J 1J7

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth
Stella		Kioke-Koostachin	89	489-073-528	June 6, 1972
Address: Street & Number / P.O. Box			**City**	**Province**	**Postal Code**
152			Attawapiskat	ON	P0L 1A0
Telephone Number		**Cell Number**		**Fax Number**	
807-264-2520					

C. EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY) 04/01/06 | Date last worked (MM/DD/YY) 10/11/13 | Number of hours 7

Reason for absence: ☑ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Work related accident or sickness ☐ Quit ☐ Retired ☐ Other ☐ Temporary Lay-off ☐ Paid Vacation

Is the employee: ☑ Full time: Number of hours worked per week _____ ☐ Part time: Number of hours worked per week _____

Is the employee: ☑ Permanent ☐ Temporary ☐ Seasonal ☐ Contract

Is the employee: ☐ Hourly ☑ Salaried ☐ Commissioned

Please attach copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If no, is a return to work date known?	Has employment terminated?
☐ Yes _____ (MM/DD/YY) ☑ No	☐ Yes _____ (MM/DD/YY) ☑ No	☐ Yes _____ (MM/DD/YY) ☑ No

D. INSURANCE INFORMATION

Date employee became insured under the Short Term Disability Plan. (MM/DD/YY)	When did the employee apply for insurance? (MM/DD/YY)	Effective date of excess insurance, if applicable: (MM/DD/YY)
01/07/06		

Is the employee covered for Guaranteed Standard Issue Program Insurance with Great-West Life? ☐ Yes _____ Plan Number ☑ No

E. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

Employee's Gross Weekly Earnings:	Average monthly commissions earned in the 24 months ending on the last day worked:	Employee benefit amount (according to your records):	TD-1 Federal personal tax credits (Dollar amount):	For Quebec residents, tax deductions according to the latest TP-1015.3:
$ 707.13 per week				

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☑ Yes ☐ No

If yes, percentage of employment income that is tax exempt: 100 %

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: Marlene Sabourin Date: October 22/13

Name (please print): Marlene Sabourin Title: Financial Controller

Phone: 807-474-4377 Fax: 807-622-1096

F. JOB INFORMATION

Employee's job title as of last day worked	How long has the employee worked in this position?
Community Legal Worker	Years 7 Months 6

COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER. If you have a prepared job description, please include it with this submission.

What are the duties in this job, and what percentage of time does each take per week?

Duties	Percentage of time per week
See attached job description.	

To ensure proper management of this claim, more detailed job information may be requested at a later date.

When did the employee's disability first appear to affect his/her work? (MM/DD/YY)	In what ways did performance on the job change as a result of the disability?
10/11/13	Off work for surgery.

Were any changes made in the employee's job duties as a result of the disability? ☐ Yes ☑ No
If yes, please explain what the changes were and when they were made:

If the employee could return to part-time or less demanding work, would such work be available? ☐ Yes ☑ No
If no, please explain.
Position is fast paced and requires worker to be at work full time due to the number of clients being serviced.

ADDITIONAL INFORMATION

Please provide any additional information that you believe should be considered in assessing this employee's claim.
Stella last day of work was the11th of October but chose to use sick leave credits and was paid up until the 18th of October, 2013.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Supervisor or Authorized Signature: Marlene Sabourin Date: October 22/13

Name (please print): Marlene Sabourin Title: Financial Controller

Phone: 807-474-4377 Fax: 807-622-1096

NISHNAWBE-ASKI LEGAL SERVICES

COMMUNITY LEGAL WORKER

JOB DESCRIPTION

DESCRIPTION:

The Community Legal Worker is the first contact clients of NALSC have with the services of the corporation, Legal Aid Ontario and the courts. CLWs are responsible for assisting clients, counsel, NALSC staff and other parties with advance and court days, referrals, diversions, PLE, legal aid applications, and for acting as ambassadors for NALSC.

DUTIES/RESPONSIBILITIES:

Pursuant to the Personnel Policies and Procedures and under the supervision of the Area Director and the Legal Aid Coordinator, duties and responsibilities of Community Legal Workers include:

1. Being available for work in the office during regular business hours, in the communities as required during advance, court and clinic days, and to be on call at other times for emergencies only;

2. As a Commissioner for taking Affidavits, perform all the functions of that office in relation to the fulfillment of the Corporation's mandate;

3. Assist community members by:
   - taking Legal Aid applications in person in a community and by telephone from remote communities when in the office;
   - assisting community members to seek legal counsel;
   - assisting community members in the completion of routine forms and providing information and referrals;
   - referring legal advice and brief service requests to staff lawyers, duty counsel and, in an emergency, to a director;
   - following up on applications to ensure all necessary documentation and information has been submitted;
   - assisting clients in dealings with justice personnel (eg. probation officers, police officers);

4. Be available in the community on advance and court days to assist legal counsel, duty counsel, community members, Restorative Justice Workers, and Victim/Witness Advocate;

5. Ensure transportation is available to and from the airport in the communities for Court party on advance and court days and arrange for office space for duty counsel/legal counsel on advance days;

6. Ensure community members are aware that duty counsel is available to provide advice to community members and arrange for radio time for duty counsel on advance days;

7. Keep Chief and Council informed regarding:
   - the status of cases
   - the location of clients
   - the times and locations of advance days and court dates;
   - the time, location and topics for clinic days

8. Follow instructions of the Area Director with regard to assisting defence counsel in the preparation of court cases;

9. Assist defence/legal counsel and duty counsel in the preparation of cases by:
   - translating/interpreting, or arranging interpreters when required
   - arranging meetings with relevant personnel;
   - assisting with the interviewing of witnesses,
   - maintaining an ongoing record of the status of cases;
   - explaining any aspect of the case to help members understand the proceedings;
   - carrying out all reasonable requests to assist in handling of cases;

10. Assist communities and Restorative Justice Workers in the development of Justice Committees;

11. Assist defence counsel, duty counsel, Restorative Justice Workers and Justice Committee members in identifying potential community diversions; inform Restorative Justice Workers and complete a referral when a matter is diverted; assist with preparations for Restorative Justice circles and ensure that reports are or have been provided to the defence and the offender;

12. Assist the Public Legal Education Coordinator:
   - in developing and delivering PLE programs in the communities,
   - serve as a continual conduit of information to and from NALSC to ensure the Corporation fulfils its mandate,
   - assisting assigned communities in any reasonable way to better understand and deal with the Euro-Canadian legal system;

13. Refer victims to the Victim Witness Advocate for assistance;

14. Participate in all relevant training workshops provided by or through the

Corporation;

15. File with the Area Director, once a month on a prescribed form, a report of all the work done and any problems encountered in that month;

16. File with the Legal Aid Coordinator, on a prescribed form, a report setting out of all courts within seven days of the court sitting;

17. Report verbally or in writing to the Area Director and Executive Director when required.

18. Perform other related duties when and as required by the Area Director, the Executive Director and the Legal Aid Coordinator, or their designates, in keeping with the furtherance of the goals and mandate of the Corporation.

ACCOUNTABILITY:

The CLWs are directly responsible to the Area Director and Legal Aid Coordinator for day to day activities and duties and are responsible to the Executive Director for overall work performance.

On a routine basis the CLW reports to the Legal Aid Coordinator for the following:

- Day to day work schedule;
- Completion of legal aid applications and supporting documentation;
- Court proceedings reports.

QUALIFICATIONS:

Highschool Diploma and some previous education or training in a law related field. Abililty to speak Ojibway, Cree or Oji-Cree a definite asset.

SALARY RANGE:

$30,000 - $55,000 per year based on a full time employee. This is a full time non-managerial position.

THE
Great-West Life
ASSURANCE COMPANY

NOVEMBER 20, 2013

PLAN ADMINISTRATOR'S EXPLANATION OF BENEFITS

RE: STELLA KIOKEE KOOSTACHIN
GROUP COVERAGE WITH
NISHNAWBE ASKI LEGAL SERVICES
DIVISION 1
PLAN NUMBER 106790
I.D. NUMBER E000000089

THE SHORT TERM DISABILITY BENEFIT FOR THE PERIOD NOVEMBER 20-26, 2013 IS:

$ 531.00 WEEKLY FOR 1 WEEK	$ 531.00
PAYMENT	$ 531.00

4364296536 FOR $ 531.00 PAID TO STELLA KIOKEE KOOSTACHIN

BENEFITS FOR THIS CLAIM HAVE NOW BEEN PAID FOR 5 WEEKS

PLEASE KEEP ALL INFORMATION CONTAINED HERE SECURE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GREAT-WEST LIFE ASSURANCE COMPANY, LONDON DISABILITY, MANAGEMENT SERVICE, 255 DUFFERIN AVENUE, LONDON, ON., N6A 4K1, OR CALL 519-432-5281.

COPY TO: STELLA KIOKEE KOOSTACHIN

THE
Great-West Life
ASSURANCE COMPANY

NOVEMBER 14, 2013

PLAN ADMINISTRATOR'S EXPLANATION OF BENEFITS

RE: STELLA KIOKEE KOOSTACHIN
GROUP COVERAGE WITH
NISHNAWBE ASKI LEGAL SERVICES
DIVISION 1
PLAN NUMBER 106790
I.D. NUMBER E000000089

THE SHORT TERM DISABILITY BENEFIT FOR THE PERIOD OCTOBER 23 - NOVEMBER 19, 2013 IS:

$ 531.00 WEEKLY FOR 4 WEEKS	$ 2,124.00
PAYMENT	$ 2,124.00

.....

4364229905 FOR $ 2,124.00 PAID TO STELLA KIOKEE KOOSTACHIN

.....

BENEFITS FOR THIS CLAIM HAVE NOW BEEN PAID FOR 4 WEEKS

PLEASE KEEP ALL INFORMATION CONTAINED HERE SECURE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GREAT-WEST LIFE ASSURANCE COMPANY, LONDON DISABILITY, MANAGEMENT SERVICE, 255 DUFFERIN AVENUE, LONDON, ON., N6A 4K1, OR CALL 519-432-5281.

COPY TO: STELLA KIOKEE KOOSTACHIN

THE Great-West Life ASSURANCE COMPANY

London Disability Management Services
255 Dufferin Ave, L1104
London, Ontario
N6A 4K1

Tel: (519) 432-7229 / 866-325-6413
Fax: (519) 435-7000

January 20, 2014

Mr. Marlene Sabourin
Business Manager
Nishnawbe Aski Legal Services
86 South Cumberland Street
Thunder Bay, ON P7B 2V3

Dear Mr. Sabourin:

RE: Stella Kiokee Koostachin
NISHNAWBE-ASKI LEGAL SERVICES
Group Plan Number 106790

Attached is a copy of a letter that has been sent out regarding Ms. Kiokee Koostachin's disability claim.

If you have any questions, please call me.

Sincerely,

Debby E

Debby E.
Case Manager

REF: 634214533-120460134 / Kiokee Koostachin01709C

THE Great-West Life ASSURANCE COMPANY

London Disability Management Services
255 Dufferin Ave, L1104
London, Ontario
N6A 4K1

Tel: (519) 432-7229 / 866-325-6413
Fax: (519) 435-7000

January 20, 2014

Ms. Stella Kiokee Koostachin
PO Box 152
Attawapiskat, ON P0L 1A0

Dear Ms. Kiokee Koostachin,

RE: Stella Kiokee Koostachin
NISHNAWBE-ASKI LEGAL SERVICES
Group Plan Number 106790
Employee ID Number E89
Portfolio ID 120460134

We have reviewed the information you provided to our office with regards to your overpayment of your short term disability benefits and find that you are incorrect. You have indicated that GWL did not pay you for two days at the beginning of your claim which were October 21, 2013 and October 22, 2013.

Under your group plan there is a 7 day waiting period for illness and this covers the period of October 16, 2013 to October 22, 2013 and your benefit payment began on October 23, 2013, therefore GWL does not owe you two sick days and the overpayment on your file remains unchanged.

Please send your cheque for full repayment to the address above as soon as possible. If you are unable to repay your overpayment of $151.71 please contact June K. at 866-325-6413 ex 7039.

Sincerely,

Debby E

Debby E.
Case Manager

Copy: Marlene Sabourin
Business Manager
NISHNAWBE-ASKI LEGAL SERVICES

REF: 634214533-120460134 / Kiokee Koostachin01709L

Dr Bill Chisholm Optometry Professional Corporation

212 - 38 Pine St. North
Timmins, Ontario, P4N 6K6
705-264-8338

Balance Due: $0.00
Printed: September 11, 2013

Mrs. Stella Koostachin-Kiokee
Box 152
Attawapiskat, ON, P0L1A1

Kindly retain this receipt for income tax purposes
Invoice date: 9/11/2013
Invoice number: 4481

Full Eye Examination, discount of $43.80	**$45.20**
Harmonized Sales Tax:	$0.00
Invoice Total:	$45.20
This payment:	$45.20 DBC

Total saving of $43.80
832265565 RT0001

Dr. Michael Flondra

Thank you for your loyalty! 24% interest on 60 days past due

DR BILL CHISHOLM
OPTOMETR
212-38 PINE ST N
TIMMINS, ON P4N6K6
7052648338

MERCHANT ID: 1657580018 TERM ID: 002

SALE

XXXXXXXXXXXXX1700
DEBIT/CHQ ENTRY METHOD: CHIP

09/11/13 14:21:43
INV #: 000044 APPR CODE: 517018
RET REF#: 000000018 BATCH #: 000324
TRACE: 0025970 REF #: 044

AMOUNT $45.20

PIN VERIFIED BY CARD ISSUER
ACCOUNT WILL BE DEBITED WITH THE
ABOVE AMOUNT
(OR CREDITED IF CREDIT VOUCHER)
RETAIN THIS COPY FOR STATEMENT
VERIFICATION

CARDHOLDER COPY

APPROVED

APPLICATION LABEL: INTERAC
AID: A0000027710010
TVR: 80 00 00 80 00
TSI: 68 00

Stella Koostachin.

Lee Brown

From: Drake, Albert <Albert.Drake@freedom55financial.com>
Sent: Wednesday, September 08, 2010 12:06 PM
To: skoostachin@nanlegal.on.ca; cwhite@nanlegal.on.ca; lbrown@nanlegal.on.ca
Subject: Foot Brace Question

Good morning everyone, I have found out some information with respect to seeking a foot brace. Great West Life would cover a foot brace but it is a process to go through first and if approved by its Medical Review Board they will cover the brace.

1. You require a prescription or letter from the doctor in order to have the foot brace and reason why you require it. What positive impacts would it provide.

2. You would need a quote/estimate from the provider and information like the materials it's made out of and what benefits this brace would provide. (The provider should have already done work like this previously for an insurer).

3. Once all the information is ready (prescription or letter from physician and your estimate and quote) this information can be sent into the claims department as a normal/regular paper medical expense claim to Great West Life.

4. The next step is the information is sent to the GWL Medical Insurance Review Board where this request will be reviewed. They will investigate/look into the request.

The more information the better so please provide physicians contact information, the maker of the foot brace, all their necessary information. This way there is sufficient information for them to base their decision on.

I hope this helps and along the way let me know how things are progressing at each stage so I can keep track where we are at with this.

Thank you Stella, Carolyn and Lee. Should you have any questions you can reach me here.

Sincerely,

Albert

Albert Drake
Financial Security Advisor
Thunder Bay Financial Centre (R0580)
Tel: (807) 343-4788 ext. 236
Cell: (807) 628-2028
Fax: (807) 343-9574

wsib cspaat ONTARIO

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR To:
41[redacted]-4684
OR 1-888-313-7373

Fax Oct 16/17

7 Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations): Community Legal Worker

Length of time in this position while working for you: 13 years

Social Insurance Number: 489 073 528

Please check if this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name: Kioke-Koostachi

First Name: Stella

Address (number, street, apt., suite, unit): PO Box 152

City/Town: Attawapiskat

Province: ON

Postal Code: P0L 1A0

Is the worker covered by a Union/Collective Agreement? ☐ yes ☒ no

Worker Reference Number:

Worker's preferred language: ☒ English ☐ French ☐ Other

Date of Birth (dd mm yy): 12 06 66

Telephone: 705-997-1285

Sex: ☐ M ☒ F

Date of Hire (dd mm yy):

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both): Nishnawbe-Aski Legal Servcies Corporation

Check one: ☐ Firm Number OR ☐ Account Number — Provide Number:

Mailing Address: 109 Mission Road

Rate Group Number:

Classification Unit Code:

City/Town: Fort William First Nation

Province: ON

Postal Code: P7J 1K7

Telephone: 807-622-1413

Description of Business Activity: Legal and paralegal services

Does your firm have 20 or more workers? ☒ yes ☐ no

FAX Number: 807-622-3024

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town: Attawapiskate

Province: ON

Postal Code: P0L 1A0

Alternate Telephone: 705-997-1285

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness (dd mm yy): 13 10 17 — ☐ AM ☒ PM 2:00

Date and hour reported to employer (dd mm yy): 13 10 17 — ☐ AM ☒ PM 5:40

2. Who was the accident/illness reported to? (Name & Position): Mary Bird, Area Director

Telephone: 807-622-1413 Ext.:

3. Was the accident/illness:
- ☒ Sudden Specific Event/Occurrence
- ☐ Gradually Occurring Over Time
- ☐ Occupational Disease
- ☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
- ☐ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☒ Fall
- ☐ Harmful Substances/Environmental
- ☐ Assault
- ☐ Other
- ☐ Slip/Trip
- ☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
- ☐ Head
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Teeth
- ☐ Neck
- ☒ Chest
- ☒ Upper back
- ☒ Lower back
- ☒ Abdomen
- ☐ Pelvis
- Left / Right: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm
- Left / Right: ☐ Wrist ☐ Hand ☐ Finger(s)
- Left / Right: ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg
- Left / Right: ☐ Ankle ☐ Foot ☐ Toe(s)
- ☐ Other

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

At 2:00 pm on Oct 13/17, Stella climbed a chair to reach for a clock and lost balance. Chair fell over and when she hit the ground she was unable to breathe and experienced a deep pain in her chest. After sitting for approximately 15 minutes she went to clinic for medical attention.

wsib cspaat ONTARIO

7 **Employer's Report of Injury/Disease (Form 7)**

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Kioke-Koostachi	Stella	489 073 528

C. Accident/Illness Dates and Details (Continued)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ■ yes ☐ no
Specify where (shop floor, warehouse, client/customer site, parking lot, etc..): **In employee's office**

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ■ no
If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ■ no
If **yes,** provide name(s), position(s), and work phone number(s).
1.
2.

10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? ☐ yes ■ no
If **yes,** please provide name and work phone number

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ■ no
If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ■ yes ☐ no
If **yes,** when: dd mm yy 13 10 17

2. When did the employer learn that the worker received health care? dd mm yy 13 10 17

3. Where was the worker treated for this injury? **(Please check all that apply)**
☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ■ Health professional office ■ Clinic
☐ Other:

Name, address and phone number of health professional or facility who treated this worker (if known)
Attending Nurse, Weeneebayko Area Health Authority, 972 Riverside East, Attawapiskat, ON, P0L 1A0

E. Lost Time - No Lost Time

1. Please choose one of the following indicators. **After the day of accident/awareness of illness, this worker:**
■ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **Has** lost time and/or earnings. **(Complete ALL remaining sections).**

Provide date worker first lost time: dd mm yy
Date worker returned to work (if known): dd mm yy ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by:
■ Myself ☐ Other Name _____ Telephone _____ Ext. _____

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ■ no

2. Has modified work been discussed with this worker? ■ yes ☐ no

3. Has modified work been offered to this worker? ■ yes ☐ no
If **yes,** was it ☐ Accepted ■ Declined
■ If Declined please attach a copy of the written offer given to the worker.

4. Who is responsible for arranging worker's return to work
☐ Myself ■ Other Name Mary Bird Telephone 807-623-1413 Ext.

wsib cspaat ONTARIO

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Kioke-Koostachi	Stella	489 073 528

G. Base Wage/Employment Information - (Do not include overtime here)

1. Is this worker **(Please check all that apply)**

- [x] Permanent Full Time
- [ ] Permanent Part Time
- [ ] Temporary Full Time
- [ ] Temporary Part Time
- [ ] Casual/Irregular
- [ ] Seasonal
- [ ] Contract
- [ ] Student
- [ ] Unpaid/Trainee
- [ ] Other
- [ ] Registered Apprentice
- [ ] Optional Insurance
- [ ] Owner Operator or (Sub) Contractor

2. Regular rate of pay $ 17.8198 per [x] hour [ ] day [ ] week [ ] other

H. Additional Wage Information

1. Net Claim Code or Amount — Federal: | Provincial:

2. Vacation pay - on each cheque? [ ] yes [ ] no — Provide percentage ____ %

3. Date and hour last worked (dd mm yy) [ ] AM [ ] PM

4. Normal working hours on last day worked — From [ ] AM [ ] PM To [ ] AM [ ] PM

5. Actual earnings for last day worked $

6. Normal earnings for last day worked $

7. Advances on wages: Is the worker being paid while he/she recovers? [ ] yes [ ] no If yes, indicate: [ ] Full/Regular [ ] Other

8. Other Earnings (Not Regular Wages): Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

▼ Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Mandatory Overtime Pay	Voluntary Overtime Pay	Commission	Commission	Commission	Commission
Week 1			$	$	$	$	$	$
Week 2			$	$	$	$	$	$
Week 3			$	$	$	$	$	$
Week 4			$	$	$	$	$	$

I. Work Schedule (Complete either **A, B or C. Do not** include overtime shifts)

[ ] **(A.) Regular Schedule** - Indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

▶ **Example:** Monday to Friday, 40 hours

S	M	T	W	T	F	S
	8	8	8	8	8	

or,

[ ] **(B.) Repeating Rotational Shift Worker** - Provide

NUMBER OF DAYS ON	NUMBER OF DAYS OFF	HOURS PER SHIFT(s)	NUMBER OF WEEKS IN CYCLE

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.

or,

[ ] **(C.) Varied or Irregular Work Schedule** - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)	/	/	/	/
Total Hours Worked				
Total Shifts Worked				

J. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2, and 3 is true.

Name of person completing this report (please print): Jeff Robert

Official title: HR General Mgr

Signature:

Telephone: 807 622 1413 Ext.

Date: dd 16 mm 10 yy 17

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

wsib cspaat ONTARIO

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Kioke-Koostachi	Stella	4 8 9 0 7 3 5 2 8

K. Additional Information

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Head Office:
200 Front Street West
Toronto, Ontario
Canada M5V 3J1

Siège social :
200, rue Front Ouest
Toronto, Ontario
Canada M5V 3J1

Telephone / Téléphone :
416-344-1000
1-800-387-0750
TTY / ATS : 1-800-387-0050

Fax / Télécopieur :
416-344-4684
1-888-313-7373

RECEIVED Oct 27/17

October 19, 2017

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION
109 MISSION RD
FORT WILLIAM FIRST NATION ON P7J 1K7
CANADA

Claim No.:	30673347
Worker Name:	STELLA KIOKEE KOOSTACHI
Date of Injury/Illness:	13/Oct/2017
Injury/Illness:	Chest, Upper Back, Lower Back, Abdomen

Dear NISHNAWBE-ASKI LEGAL SERVICES CORPORATION,

To keep you informed of the claim status, attached is a copy of a letter sent to STELLA KIOKEE KOOSTACHI.

I have made this decision based on the information available to me. If you do not understand the decision, or if you do not agree with the conclusions reached, please call me. I would be pleased to discuss your concerns.

It is important to know that the *Workplace Safety and Insurance Act* (the *Act*) imposes time limits on objections. If you want to object to my decision, the Act requires that you notify me in writing no later than April 19, 2018.

To submit this written appeal notice, please go to our website at www.wsib.on.ca and complete the Intent to Object Form. There is an instruction sheet included on the site which also lists organizations that can provide free representation. You can access the form and instruction sheet by typing "appeal" into the search box on the website and accessing the Worker Appeals or Employer Appeals page. They are also available in the "Forms" section of the website. If you do not have access to our website, you may call our toll free number at 1-800-387-0750 and request the form be mailed to you.

Yours sincerely,

Operations Division
Tel: 416-344-1000 or 1-800-387-0750

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Head Office:
200 Front Street West
Toronto, Ontario
Canada M5V 3J1

Siège social :
200, rue Front Ouest
Toronto, Ontario
Canada M5V 3J1

Telephone / Téléphone :
416-344-1000
1-800-387-0750
TTY / ATS . 1-800-387-0050

Fax / Télécopieur :
416-344-4684
1-888-313-7373

October 19, 2017

STELLA KIOKEE KOOSTACHI
PO BOX 152
ATTAWAPISKAT ON P0L 1A0
CANADA

Claim No.: 30673347

Worker Name: STELLA KIOKEE KOOSTACHI

Date of Injury/Illness: 13/Oct/2017

Injury/Illness: Chest, Upper Back, Lower Back, Abdomen

Dear STELLA KIOKEE KOOSTACHI,

We are sorry to hear about your recent injury/illness at work. The claim filed for health care benefits for your work-related Chest, Upper Back, Lower Back, Abdomen injury/illness has been allowed, as it does not appear that you missed any time from work after the date of your injury or illness. If you did miss time from work due to this injury/illness, please contact us as you may also be eligible for loss of earnings (LOE) benefits.

If you experience ongoing recovery issues because of your injury or illness, or if you have not returned to your regular work duties after 14 days, please contact the WSIB to let us know. We may be able to offer you additional services to help in your recovery and return to work.

Helping in Your Recovery and Return to Work

Workers, employers and the WSIB all have responsibilities as workplace partners, with many of these responsibilities required under the law. Your help is needed during your recovery and return to work. Please keep up with health care treatments, stay in touch with your employer, and provide the WSIB with the information we request to manage your claim.

You can help us manage your claim more quickly and efficiently by submitting a completed *Worker's Report of Injury/Disease (Form 6)* to receive benefits from the WSIB if not already done. Available online, this "eForm6" can be submitted to us securely through our website at www.wsib.on.ca via the "eServices" option on our welcome page. You will need your claim number (see above) and your date of birth to complete the eForm6.

You must report the following changes in your circumstances to the WSIB within 10 days of the change to ensure the benefits you are receiving are not reduced or stopped, and that you are not subject to a penalty:

- An improvement or worsening in your condition,
- An increase or decrease in your wages,
- Beginning to get, or changes, to Canada Pension Plan disability benefits,
- A change in your job duties or hours, and/or
- A change in your ability to co-operate in treatment, early and safe return-to-work activities, or work reintegration program.

Please contact us if you are unsure if you need to report a material change. We can review the information and decide if adjustments to your benefits are necessary.

As part of our responsibilities, the WSIB is committed to protecting your privacy and the confidentiality of your personal information. You can read our detailed Privacy Statement for Workers on our website or contact us to send you a copy.

About Health Care Services/Equipment and/or Supplies

As a result of your injury or illness, you may need health care services including treatment, medication and health care equipment and supplies that have been prescribed to treat your work-related injury or illness. Pharmacies and health care providers should bill the WSIB directly at the approved fee and should not bill you for any services you receive. Sometimes a service or product may need to be pre-approved to ensure the payment is allowed. In these cases, the service provider or supplier should contact the WSIB to obtain approval for the medication, treatment, equipment or supplies.

Health Care Equipment and Supplies

If you require health care equipment or supplies as a result of your work-related injury or disease, a prescription is required from your treating practitioner.

For purchases of most standard products, please use one of the four suppliers listed below. Please note that custom made orthotics may be purchased from the vendor of your choice.

By using these preferred suppliers, you will not have any out-of-pocket expenses and you can expect a wide range of high quality products, retail locations across Ontario, and excellent service – including fast home delivery to anywhere in Ontario, at no cost to you. This chart provides contact information and a description of the services offered by each preferred supplier.

Preferred Supplier	Contact & Order Information	Location
McKesson Retail Banner Management	Phone: 1-844-989-1784 Website: www.hhcesprovider.ca	Province-wide with over 75 independently-owned locations. Banner stores include IDA Drugmart and Guardian Pharmacy
Ontario Home Health	Contact local stores to place orders Website : www.ont-home-health.on.ca	Central and Southwestern Ontario: Stratford, Orangeville, Guelph and Cambridge. Specializing in rural support for these areas.
Motion Specialties	Contact local stores to place orders. Website: www.motionspecialties.com	Province-wide with about 22 retail locations across Ontario
Shoppers Home Health Care	Phone: 1-888-603-4369 Website: www.shoppershomehealthcare.ca	Storefront locations across Ontario

You can get detailed information about WSIB benefits and services, fact sheets and other publications in several languages and formats, our privacy statement and our policies online at www.wsib.on.ca.

Health Care Benefits

The WSIB has an automated drug benefit program. This lets pharmacies across Canada bill us electronically for medication prescribed for a work related injury/illness that has been allowed by the WSIB.

To get your prescription filled, simply take your prescription to a Canadian pharmacy. Your pharmacist will need your claim number to process your prescription. The prescription information is sent electronically through the WSIB's online system and if you have entitlement to this drug, then the pharmacist can fill your prescription immediately and bill the WSIB.

Sometimes you may have to pay for your prescription and then request reimbursement from the WSIB. This happens if:

- Your claim is not yet approved or you have not used the pharmacy billing system before. For new claims, call 1-800-655-4631 to check your status.
- A particular medication is not covered.
- The quantity of the drug requested is more than your entitlement. The WSIB is still reviewing entitlement to a particular medication.

Reimbursement for a prescription that you paid can be requested. You must:

- Complete and sign a WSIB Medication Reimbursement Form (0806A), which is available from pharmacies and the www.wsib.on.ca or by calling the above noted number.
- Attach the original receipts, and
- Send it to the WSIB for consideration of payment to:

  Drug Verification
  Workplace Safety and Insurance Board
  200 Front Street West
  Toronto ON M5V 3J1

Travel Expenses

The WSIB pays all reasonable expenses incurred when, on the direction or approval of the WSIB, a worker or another person designated by the WSIB, must travel in relation to a claim.

If you are not sure of the type of travel expenses for which you are eligible, please call the WSIB or visit our website, www.wsib.on.ca for more information. A Worker's Travel Expense Form is available on the website to complete. We must pre-approve travel expenses. Please complete the form based on the method of travel we have approved, even if you choose to travel a different method. For example, if you are eligible for public transit fare and choose to drive, you should complete the form claiming transit fares. Be sure to provide all the information requested so that we can process your payment promptly.

Additional Support for Workers

Some workers find it helpful to have a worker representative assist them with their WSIB case. Free advice and representation may be available through your local union or through the following organizations:

- The Ontario Federation of Labour (OFL), toll free at 1-800-668-9138.
- The Office of the Worker Adviser (OWA), toll free at 1-800-435-8980.
- Community Legal Clinics. Legal Aid Ontario toll free at 1-800-668-8258.

We are available to answer any questions you may have about anything in this letter or about your claim. Please contact us at the number below.

Yours sincerely,

Operations Division
Tel: 416-344-1000 or 1-800-387-0750

Copy To:NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

Manulife

Group Benefits
Attending Physician Statement
Short Term Group Disability Claim

FAXED 02/10/19

The purpose of this Statement is to assist Manulife in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. PLEASE KEEP A COPY FOR YOUR RECORDS.

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO
Waterloo ON N2J 4C2

Tel: 1-877-481-9169 • (519) 747-7000
Fax: 1 866 677-4215 • (519) 579-3680
Email: group_disability_claims@manulife.com

1 Plan member/employee information and consent (To be completed by patient.)

Plan member/employee name (last, first, middle initial)	Home phone number	Cell phone number
Kiokee-Keostachin, Stella M	(705) 997-2308	705 266-5257

Address (number, street, apt.)	City	Province	Postal code
Box 152	Attawapiskat	ON	P0L1A0

Plan sponsor name	Plan contract number	Plan member certificate number
Nishnawbé-Aski Legal Services Corporation	110020	

Height	Weight	Date of birth (dd/mmm/yyyy)
5'6"	253 lbs	12/08/66

Last date worked (dd/mmm/yyyy)	Date returned to work or expected return to work date (dd/mmm/yyyy)
27/09/19	

I hereby authorize the release of medical and health information in my file to Manulife and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Stella Kiokee-Keostachin — Plan member/Employee signature
01/10/2019 — Date (dd/mmm/yyyy)

2 Attending physician's statement

STOP

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the *last date worked*, complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary: right knee medial meniscal tear
Secondary:

If childbirth provide expected or actual delivery date (dd/mmm/yyyy)
Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☑

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)
10/2018	30/09/2015

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☑ Date admitted (dd/mmm/yyyy): 30/09/2015
Name of institution: TADH Date discharged (dd/mmm/yyyy):

If surgery was performed provide date and description of surgery.
Date (dd/mmm/yyyy): Description: Rt knee arthroscopy

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery
off work x 6 mo

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☑ If yes, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Knee pain + swelling

Frequency of Visits ☐ Weekly ☑ Monthly ☐ Other

Attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit _____

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

To your knowledge, is the patient following the recommended treatment program? Yes ☑ No ☐

In your opinion, is your patient competent to manage his/her own affairs? Yes ☑ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2) recovery

→ expect complete recovery 6 wks post-op

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending physician (please print)	Certified specialist	Physician's stamp
Dr R Lafontaine	Orthopedic	
Address (number, street, suite)		
1040 Ross Ave E		
City	Province / Postal code	
Timmins	ON P4N 0A2	
Telephone number	Fax number	
(705) 3605330	(705) 360-5313	
Signature	Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

Manulife

Group Benefits Plan Member Statement
Group Disability Claim Form

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form. Refer to your booklet for information about your plan.

Please send completed form to:
Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

1 Benefit application **Please select the benefit type for which the plan member is applying.**

○ Short term disability ○ Long term disability ○ Waiver of premiums ○ Critical illness ○ Dismemberment

2 Plan member information **You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.**

Plan sponsor name Nishnawbek-Aski Legal Services Corportatoin

Plan contract number 110020 Division 000 Certificate number 1

Full name (first, middle initial, last) Stella Maclean Kidree-Koostachus

SIN (if benefit is taxable) 489 073 528 Date of birth (dd/mmm/yyyy) 12-08-66 Sex F

Height 5'6" Weight 253 lbs Number of dependents and ages -0- Language preference: ☑ English ○ French

Street address (number, street, apt) Box 152

City Attawapiskat Province ON Postal code P0L 1A0

Primary phone number (705) 997-1285 Alternate phone number (705) 997-2308

Work phone number (705) 997-1285 Ext. _____

By providing my personal email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

Email address StellaKK2001@yahoo.ca / skoostachus@nanlegal.on.ca

3 Direct deposit authorization **If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.**

○ If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement

☑ If depositing into a chequing account, please sign the authorization, and attach a copy of a void cheque

Name of financial institution Scotiabank

Address of financial institution (number, street, suite) 1 Pine street

City Timmins Province ON Postal code P4N 2J5

Type of account: ☑ Chequing ○ Savings

Branch or transit number (5 digits) 11072 Institution number (3 digits) 002

Bank account number (maximum 12 digits) 000 1820125

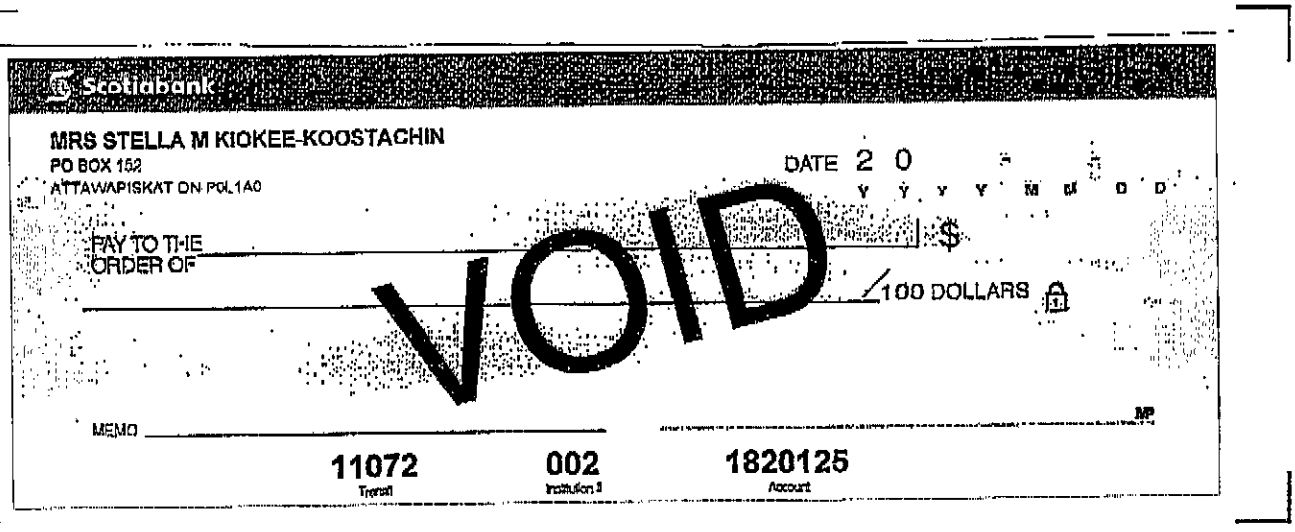
Continued on the next page.

3 Direct deposit authorization (continued)

I hereby authorize Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. I agree that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, I authorize the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan member signature Stella Kiokee-Koostachin Date (dd/mmm/yyyy) _____

Plan member name (please print) Stella Kiokee-Koostachin



4 Injury information

Occupation Community Legal Worker Original date of hire (dd/mmm/yyyy) 24/10/2004 SKK

Is your injury/illness work related? ○ Yes ◉ No

If no, was the reason you stopped working due to: ○ Illness ○ Injury away from work ○ Motor vehicle accident (Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

Is there any legal action? ○ Yes ◉ No If yes, please provide the lawyer's contact information.

Lawyer's name _____ Phone number ( ) _____ Ext. _____

Lawyer's address (number, street, suite) _____

City _____ Province _____ Postal code _____

5 Work information

What was the last date at work? (dd/mmm/yyyy) 27-09-2019

Was this a full day/shift? ◉ Yes ○ No If *no*, how many hours were worked on your last day? _____

Have you performed any other paid or volunteer work since that date? ○ Yes ◉ No

If *yes*, please describe. Dates (dd/mmm/yyyy)

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

6 Illness information When were you first treated by a physician for the current absence? (dd/mmm/yyyy) _____

Please describe your symptoms and their frequency.

What work duties do your symptoms prevent you from performing?

Have you ever had the same or similar illness or injury? ○ Yes ✓ No

Did it result in an absence from work? ○ Yes ✓ No If yes, please describe, include dates and treatment provided.

Do you have an expected return to work date? ✓ Yes ○ No If yes, please provide the date (dd/mmm/yyyy) 14-10-2019

7 Health care professional information **Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.**

Name Dr. Robert Lafontaine Specialty Orthopedic Surgeon

Address of health care professional (number, street, suite) 640 Ross Ave

City Timmins Province ON Postal code P4N 2K3

Phone number (705) 360-5330 Fax number (705) 360-5313

Consulted: From: (dd/mmm/yyyy) October 2018 To: (dd/mmm/yyyy) Presently

Date of next visit (dd/mmm/yyyy) 30-09-2019 Frequency of visits Cortisone Injections ± 3 mos

Name Weeneebayko Health Authority Specialty Hospital

Address of health care professional (number, street, suite) General Delivery

City Attawapiskat Province ON Postal code P0L 1A0

Phone number (705) 997-2458 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 16-08-2018 To: (dd/mmm/yyyy) -10-2018

Date of next visit (dd/mmm/yyyy) N/A Frequency of visits Pain management/diagnos

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number ( ) _____ Fax number ( ) _____

Consulted: From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

8 Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.

Source	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Date benefit commenced? (dd/mmm/yyyy)	Amount ($)	Please describe or provide claim number, contact name and telephone number
Canada/Quebec Pension Plan							
◯ Disability	◯	✓	◯	✓			
◯ Retirement							
Worker's compensation*	◯	✓	◯	✓			
Employment Insurance	◯	✓	◯	✓			
Auto Insurance	◯	✓	◯	✓			
Other insurance	◯	✓	◯	✓			
Income from any other source	◯	✓	◯	✓			

*Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

9 When to contact Manulife

NOTIFY MANULIFE PROMPTLY IN THE FOLLOWING CASES

I acknowledge I must notify Manulife immediately if:

a) my medical condition improves, even though I have not yet returned to work
b) I start work either as an employee or a self-employed person
c) I apply for benefits under any workers' compensation law or plan as defined in section 8
d) I apply for benefits under Canada/Quebec Pension Plan
e) I receive any benefits or income from any other source
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disability
h) I am leaving the country or travelling
i) I am or will be returning to school

Plan member signature Stella Kiokee-Koostachin Date (dd/mmm/yyyy) _____

10 Agreement, authorization and acknowledgement

Please sign this authorization and send to Manulife using one of the following methods.

Via fax:	(519) 579-3680 or 1-866-677-4215
Via email:	group_disability_claims@manulife.com
Via regular mail to:	**Manulife Group Benefits** Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2

I confirm:

- that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- that my claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- I am required to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, and I authorize Manulife to deduct monies from my group benefits.
- that a photocopy or electronic version of this authorization shall be as valid as the original.

I authorize:

- Manulife and/or its service providers, its reinsurers and its service providers, and any person or organization who has personal information about me, including an administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claim(s), including independent medical assessments.
- Manulife to use my SIN for the purposes of tax reporting and identification and administration. If my SIN is used as my plan member certificate number.
- Manulife to release information to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor for plan administration purposes.

I acknowledge:

- that my medical information will not be provided to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor unless my consent is explicitly obtained.
- that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy, available at **https://www.manulife.ca/corporate/privacy-policy.html** or from my Plan Sponsor.
- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of my personal information will be limited to Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife and I understand that this may impact the administration of my claim and any benefit payment.

Plan member signature Stella Kiokee-Koostachin Date (dd/mmm/yyyy) October 8, 2019

Plan member name (please print) Stella Kiokee-Koostachin

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.

10/17/2019 09:12

=== COVER PAGE ===

TO: _____

FROM: _____

FAX: 17059979955

TEL:

COMMENT:

Family Medicine Clinic
Weeneebayko General Hospital
P. O. Box 34
Moose Factory, ON
P0L 1W0

Wednesday, October 16, 2019

Re: Stella Kiokee-Koostachin
Box 152 160 CEDAR ST.
Attawapiskat
P0L 1A0

To Whom It May Concern:

This patient was seen on Wednesday, October 16, 2019.

This patient was totally disabled on Wednesday, October 16, 2019.

Estimated time until return to work: 2 Weeks.

This information was confirmed on the basis of my direct examination or management of this patient.

Additional Notes:
Due to injury.

NP-PHC
#968 0315
Brenda Louttit-Bunker

Family Medicine Clinic
Weeneebayko General Hospital
P. O. Box 34
Moose Factory, ON
P0L 1W0

Wednesday, October 16, 2019

Re: Stella Kiokee-Koostachin
Box 152 160 CEDAR ST.
Attawapiskat
P0L 1A0

To Whom It May Concern:

This patient was seen on Wednesday, October 16, 2019.

This patient was totally disabled on Wednesday, October 16, 2019.

Estimated time until return to work: 2 Weeks.

This information was confirmed on the basis of my direct examination or management of this patient.

Additional Notes:
Due to injury.

NP-PHC
#968 0315
Brenda Louttit-Bunker

Family Medicine Clinic
Weeneebayko General Hospital
P. O. Box 34
Moose Factory, ON
P0L 1W0

Wednesday, October 16, 2019

Re: Stella Kiokee-Koostachin
Box 152 160 CEDAR ST.
Attawapiskat
P0L 1A0

To Whom It May Concern:

This patient was seen on Wednesday, October 16, 2019.

This patient was totally disabled on Wednesday, October 16, 2019.

Estimated time until return to work: 2 Weeks.

This information was confirmed on the basis of my direct examination or management of this patient.

Additional Notes:
Due to injury.

NP-PHC
#968 0315
Brenda Louttit-Bunker

Manulife

Group Benefits Sponsor Statement
Group Disability Claim

E-MAILED OCT 16 2019

- Please ensure to answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- This notification must be sent to Manulife without delay.

Please send this form to:
Manulife Group Benefits
Attention: Disability Claims
PO BOX 800, STN WATERLOO, Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000 Fax: 1-866-677-4215 or (519) 579-3680
E-mail: group_disability_claims@manulife.com

1 Benefit application

Please select the benefit type for which the plan member is applying:

(●) Short-term disability ( ) Long-term disability ( ) Waiver of premiums ( ) Critical illness ( ) Dismemberment

2 Plan sponsor information

Plan contract number 110020 Plan sponsor name Nishanawbe-Aski Legal Services Corporation

Street address (number, street, suite) 1805 E Arthur St.,

City Thunder Bay Province ON Postal code P7E 2R6

Plan sponsor contact name Colette Shwetz Job title HR Manager

Phone number (807) 622-1413 Fax (807) 622-3024 E-mail cshwetz@nanlegal.on.ca

Health centre contact and return work contact
If different from above, please indicate the person in the health centre involved in disability absences.

Name _____ Job title _____

Phone number ( ) E-mail _____

If different from above, please indicate the person we should contact to facilitate a return to work once this employee's abilities and limitations are known.

Name _____ Job title _____

Phone number ( ) E-mail _____

3 Plan member identification and work information

Full name (first, middle initial, last) Stella Kiokee-Koostachin

Date of birth (dd/mmm/yyyy) 12/Jun/1966

Certificate number 23 Primary phone number (705) 997-2308 Alternate phone number ( )

Class A Division _____ Job title Community Legal Worker

Permanent employee (●) Yes ( ) No Date of hire (dd/mmm/yyyy) 01/Apr/2006

Date for which the plan member was first covered under this plan. Date (dd/mmm/yyyy) 01/Jul/2006

Has there been any interruption in the plan member's coverage? ( ) Yes (●) No

Please indicate the **HOURS** of work in a normal week.

Is this shift work? ( ) Yes (●) No

If *yes*, please indicate the work schedule or attach a copy of the work schedule.

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours of work each day	7	7	7	7	7		

Provide details if plan member's shift schedule is varied or rotational: _____

Is the member required to work night shift? ( ) Yes ( ) No

Plan member's gross salary as of the last day of work $ 3,737.10 ( ) Per week (●) Per month

Was the plan member: ( ) Salaried (●) Hourly

What was the last date at work? Date (dd/mmm/yyyy) 30/09/2019

3 Plan member identification and work information (continued)

Was this a full day/shift? ◉ Yes ○ No

If *no*, how many hours were worked? _____ Is the absence work related? ○ Yes ◉ No

What was the plan member's first missed day of work? Date (dd/mmm/yyyy) _____

Has the plan member returned to work? ○ Yes ◉ No If *yes*, when? Date (dd/mmm/yyyy) _____

Did the plan member return to: ◉ Regular duties ○ Modified duties

Tax Information - Please complete only if the benefit is taxable

TD1 code _____ TP1 code _____ Plan member's province of residence for income tax purposes _____

Is employment income tax exempt according to terms of Indian Act and Income Tax Act? ○ Yes ○ No If *yes*, please provide copy of TD1-IN.

Please indicate if any of the following have been paid (or are payable) since date plan member last worked

	Amount	Dates (dd/mmm/yyyy)
Salary continuance	_____	From _____ To _____
Vacation	_____	From _____ To _____
Sick Leave	_____	From _____ To _____
Severance	_____	From _____ To _____
Employment Insurance benefits	_____	From _____ To _____
Other * _____ (please indicate the source)	_____	From _____ To _____

*E.g. Short-term disability benefits, commissions or bonuses, retirement pension. If more space is needed, please use a separate sheet of paper.

4 Life coverage

To be completed for self-administered groups applying for waiver of premium or please provide a copy of the Enrolment Application.

Group Life Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Annual salary $_____ Date of last increase (dd/mmm/yyyy) _____

Life coverage when last actively at work ○ Terminated ○ Active ○ Suspended

Amount of Life coverage

○ Basic $_____ ○ Spousal $_____ ○ Dependent Children $_____

○ Optional $_____ ○ Optional Spousal $_____ ○ Other _____ (specify) $_____

Group Accidental Death and Dismemberment Benefit (AD & D)

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of AD & D coverage

○ Basic $_____ ○ Optional $_____ ○ Spousal $_____ ○ Optional Spousal $_____

Group Survivor Income Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Monthly survivor benefit amount $_____ Type of coverage ○ Spousal ○ Spousal and children ○ Other (specify) _____

Critical Illness Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of Critical Illness Benefit

○ Plan member basic $_____ ○ Plan member optional $_____ ○ Spousal $_____ ○ Child $_____

5 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Name Colette Shwetz. Title HR Manager

Signature Colette Shwetz Date (dd/mmm/yyyy) 15/10/19.

Please ensure section 6 is completed by the plan member's supervisor.

6 Occupational information

This section may be separated from the rest of the form if necessary. Please attach a physical demands analysis if available.

Completed by:

Name and title: Heather Baillie

Date completed (dd/mmm/yyyy): 15/Oct/2019

What was the plan member's occupation immediately prior to the plan member stopping work? Community Legal Worker

Were the plan member's duties and/or hours modified from their regular occupation? ○ Yes ◉ No If so, when? (dd/mmm/yyyy) _____

Please describe this plan member's regular duties (or attach a copy of the company's job description) as well as any modifications, if any.

Job description attached

7 Occupational demands

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the frequency for which the following activities are regularly performed:

PHYSICAL ACTIVITIES

Activity	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Walking	○	◉	○	○
Sitting	○	○	◉	○
Standing	○	◉	○	○
Driving / Operating machinery	◉	○	○	○
Climbing up and down the stairs	○	◉	○	○

Does the employee's occupation require repetitive movements? ○ Yes ◉ No

Lifting	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	○	◉	○	○
11-20 lb.	◉	○	○	○
21-50 lb.	◉	○	○	○
51-100 lb.	◉	○	○	○
100+ lb.	◉	○	○	○

Pushing/ Pulling	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	○	◉	○	○
11-20 lb.	◉	○	○	○
21-50 lb.	◉	○	○	○
51-100 lb.	◉	○	○	○
100+ lb.	◉	○	○	○

Does the plan member use a lifting device? ○ Yes ○ No

COGNITIVE ACTIVITIES

Activity	Definition	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Understanding and memory	Understanding and remembering instructions	○	○	◉	○
Sustained concentration	Maintaining attention and concentration for extended periods	○	○	◉	○
Social interaction	Interaction with co-workers and/or the general public	○	○	◉	○
Adaptation and multitasking	Response to frequent changes, juggle tasks and prioritizes	○	○	◉	○
Meeting deadlines	The work involves time pressure and deadlines	○	○	◉	○
Responsibility and accountability	Errors in judgement or attention can have significant consequences	○	○	◉	○

8 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Name: Colette Shuetz Title: HR Manager

Signature: Colette Shuetz Date (dd/mmm/yyyy): 15/10/2019

Please note: The information in this statement will be kept in a group life, health or disability benefits file with Manulife and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

NISHNAWBE-ASKI LEGAL SERVICES

COMMUNITY LEGAL WORKER

JOB DESCRIPTION

DESCRIPTION:

The Community Legal Worker is the first contact clients of NALSC have with the services of the corporation, Legal Aid Ontario and the courts. CLWs are responsible for assisting clients, counsel, NALSC staff and other parties with advance and court days, referrals, diversions, PLE, legal aid applications, and for acting as ambassadors for NALSC.

DUTIES/RESPONSIBILITIES:

Pursuant to the Personnel Policies and Procedures and under the supervision of the Area Director and the Legal Aid Coordinator, duties and responsibilities of Community Legal Workers include:

1. Being available for work in the office during regular business hours, in the communities as required during advance, court and clinic days, and to be on call at other times for emergencies only;

2. As a Commissioner for taking Affidavits, perform all the functions of that office in relation to the fulfillment of the Corporation's mandate;

3. Assist community members by:
   - taking Legal Aid applications in person in a community and by telephone from remote communities when in the office;
   - assisting community members to seek legal counsel;
   - assisting community members in the completion of routine forms and providing information and referrals;
   - referring legal advice and brief service requests to staff lawyers, duty counsel and, in an emergency, to a director;
   - following up on applications to ensure all necessary documentation and information has been submitted;
   - assisting clients in dealings with justice personnel (eg. probation officers, police officers);

4. Be available in the community on advance and court days to assist legal counsel, duty counsel, community members, Restorative Justice Workers, and Victim/Witness Advocate;

5. Ensure transportation is available to and from the airport in the communities for Court party on advance and court days and arrange for office space for duty counsel/legal counsel on advance days;

6. Ensure community members are aware that duty counsel is available to provide advice to community members and arrange for radio time for duty counsel on advance days;

7. Keep Chief and Council informed regarding:
   - the status of cases
   - the location of clients
   - the times and locations of advance days and court dates;
   - the time, location and topics for clinic days

8. Follow instructions of the Area Director with regard to assisting defence counsel in the preparation of court cases;

9. Assist defence/legal counsel and duty counsel in the preparation of cases by:
   - translating/interpreting, or arranging interpreters when required
   - arranging meetings with relevant personnel;
   - assisting with the interviewing of witnesses,
   - maintaining an ongoing record of the status of cases;
   - explaining any aspect of the case to help members understand the proceedings;
   - carrying out all reasonable requests to assist in handling of cases;

10. Assist communities and Restorative Justice Workers in the development of Justice Committees;

11. Assist defence counsel, duty counsel, Restorative Justice Workers and Justice Committee members in identifying potential community diversions; inform Restorative Justice Workers and complete a referral when a matter is diverted; assist with preparations for Restorative Justice circles and ensure that reports are or have been provided to the defence and the offender;

12. Assist the Public Legal Education Coordinator:
   - in developing and delivering PLE programs in the communities,
   - serve as a continual conduit of information to and from NALSC to ensure the Corporation fulfils its mandate,
   - assisting assigned communities in any reasonable way to better understand and deal with the Euro-Canadian legal system;

13. Refer victims to the Victim Witness Advocate for assistance;

14. Participate in all relevant training workshops provided by or through the

Corporation;

15. File with the Area Director, once a month on a prescribed form, a report of all the work done and any problems encountered in that month;

16. File with the Legal Aid Coordinator, on a prescribed form, a report setting out of all courts within seven days of the court sitting;

17. Report verbally or in writing to the Area Director and Executive Director when required.

18. Perform other related duties when and as required by the Area Director, the Executive Director and the Legal Aid Coordinator, or their designates, in keeping with the furtherance of the goals and mandate of the Corporation.

ACCOUNTABILITY:

The CLWs are directly responsible to the Area Director and Legal Aid Coordinator for day to day activities and duties and are responsible to the Executive Director for overall work performance.

On a routine basis the CLW reports to the Legal Aid Coordinator for the following:

- Day to day work schedule;
- Completion of legal aid applications and supporting documentation;
- Court proceedings reports.

QUALIFICATIONS:

High school Diploma and some previous education or training in a law related field. Ability to speak Ojibway, Cree or Oji-Cree a definite asset.

Updated June 2004

Colette Shwetz

From: Morgan Godwin <Morgan_Godwin@manulife.ca>
Sent: May 6, 2021 7:28 AM
To: Colette Shwetz
Subject: FW: Kiokee-Koostachin, Stella, STD Claim Status Update

Hello Colette!

Updated information regarding the STD claim for Stella was received on May 4, 2021.

Based on a review of all the information on file, Stella's expected return to work date is June 1, 2021 and benefits have been extended up to and including May 31, 2021.

We anticipate that Stella will be able to return to her regular duties on a full time basis on this date. In the event that Stella is unable to return to work, she will need to contact Manulife and will be required to provide additional information to support the extended absence. This information has been outlined to Stella as well.

If you have any questions/concerns, please let me know.

Thank you!

Morgan Godwin

Case Manager

E Morgan_Godwin@manulife.com **T** 519 747 7000 ext. 234877 **F** 519 579 3680

Manulife

PO Box 800 Stn Waterloo, Ontario, Canada, N2J 4C2

Manulife.ca

Need to chat with me? Click here to book some time so we can connect.

From: Morgan Godwin
Sent: Tuesday, May 4, 2021 1:03 PM
To: cshwetz@nanlegal.on.ca
Subject: FW: Kiokee-Koostachin, Stella, STD Claim Status Update

Hello Colette!

Just wanted to touch base with you and let you know that I attempted to connect with Stella via telephone this morning and left a voicemail.

I also sent her an email should that be a more convenient way of responding to me.

I will continue to keep you up to date regarding the status of her claim and when she has provided a response to either the voicemail or email sent.

Any questions/concerns, please let me know.

Thank you!

Morgan Godwin

Case Manager

E Morgan_Godwin@manulife.com **T** 519 747 7000 ext. 234877 **F** 519 579 3680

Manulife

PO Box 800 Stn Waterloo, Ontario, Canada, N2J 4C2

Manulife.ca

Benefits fraud hurts us all. Be part of the solution. manulife.ca/shareandprotect

Need to chat with me? Click here to book some time so we can connect.

From: Morgan Godwin
Sent: Monday, May 3, 2021 12:51 PM
To: cshwetz@nanlegal.on.ca
Subject: Kiokee-Koostachin, Stella, STD Claim Status Update

Hello Colette!

I have received your voicemail regarding Stella's STD claim.

Stella did email me on Saturday, May 1, 2021 with some updated information.

Stella also left me a voicemail this morning, May 3, 2021. I have just returned her call, however, there was no answer.

I will attempt to reach out to her again tomorrow to see if we can connect via telephone.

If you have any questions/concerns, please let me know.

Morgan Godwin

Case Manager

E Morgan_Godwin@manulife.com **T** 519 747 7000 ext. 234877 **F** 519 579 3680

Manulife

PO Box 800 Stn Waterloo, Ontario, Canada, N2J 4C2

Manulife.ca

Benefits fraud hurts us all. Be part of the solution. manulife.ca/shareandprotect

Need to chat with me? Click here to book some time so we can connect.

SCANNED

Nishnawbe-Aski Legal Services Corporation

Functional Capacity Assessment (Full) Form

RELEASE OF INFORMATION

I, Stella Kiokee-Koostachin, authorize _____ to supply written information to my employer, Nishnawbe-Aski Legal Services Corporation regarding my residual functional capacity; any limitations or restrictions on my ability to perform the functions of my position; and any devices, equipment, or accommodations I require to enable me to perform these functions.

Employee's signature _____ Date: _____

FUNCTIONAL CAPACITY ASSESSMENT

Employee's name: Stella Kiokee-Koostachin

Health care provider: Please answer only the elements that are pertinent to the employee's ability to perform the essential functions of his job. Explain any response in more detail in Section C.

Date of assessment: 07/10/2021 (surgery)

Please check one of the following:

- ☐ Employee is capable of returning to work with no restrictions.
- ☐ Employee is capable of returning to work with restrictions. Complete sections A, B, and C.
- ☑ Employee is physically or mentally unable to return to work at this time. Complete Section C.

X 6 months post-op

Section A. Physical Functional Capacity Assessment

1. Please indicate *abilities* that apply. Include additional details in Section C. If not applicable, see Section B.

Walking
- ☐ Full abilities
- ☐ Fewer than 100 metres
- ☐ 100–200 metres
- ☐ Other (please specify)

Standing
- ☐ Full abilities
- ☐ Fewer than 2 hours
- ☐ At least 2 hours
- ☐ About 6 hours
- ☐ Other (please specify)

Sitting
- ☐ Full abilities
- ☐ Fewer than 30 minutes
- ☐ 30 minutes–1 hour
- ☐ Other (please specify)

Lifting—floor to waist
- ☐ Full abilities
- ☑ Fewer than 5 kilograms
- ☐ 5–10 kilograms
- ☐ Other (please specify)

Lifting—waist to shoulder
- ☐ Full abilities
- ☐ Fewer than 5 kilograms
- ☐ 5–10 kilograms
- ☐ Other (please specify)

Stair climbing
- ☐ Full abilities
- ☐ Fewer than 5 steps
- ☑ 5–10 steps
- ☐ Other (please specify)

Ladder climbing
- ☐ Full abilities
- ☐ 1–3 steps
- ☐ 4–6 steps
- ☐ Other (please specify)

Travel to work

Able to use public transit:
- ☐ Yes
- ☐ No

Able to drive a car:
- ☐ Yes
- ☐ No

2. Please indicate *restrictions* that apply. Include additional details in Section C.

☐ Bending/twisting

☐ Repetitive movement of (please specify)

☐ Capacity to work at or above shoulder

☐ Chemical exposure to

☐ Environmental exposure to (e.g., heat, cold, noise, or scents)

☐ Operating motorized equipment (e.g., forklift)

☐ Limited use of hand(s)

Left	Right
☐ Gripping	☐
☐ Pinching	☐
☐ Other	☐

☐ Limited pushing/pulling with
- ☐ Left arm
- ☐ Right arm
- ☐ Other (please specify)

☐ Potential side effects from medications (please specify). Do not include the names of medications.

☐ Exposure to vibration
- ☐ Whole body
- ☐ Hand/arm
- ☐ Other (please specify)

☐ Visual/communicative
- ☐ Acuity (depth, colour, or field)
- ☐ Hearing
- ☐ Speaking
- ☐ Other (please specify)

off work 6 months post op 2

Section B: Mental Functional Capacity Assessment

If not applicable, see Section C

	No limitation	Not significantly limited	Moderately limited	Markedly limited	Not able to assess
1. Understanding and memory					
a. The ability to remember locations and work-like procedures	☑	☐	☐	☐	☐
b. The ability to understand and remember very short and simple instructions	☑	☐	☐	☐	☐
c. The ability to understand and remember detailed instructions	☑	☐	☐	☐	☐

	No limitation	Not significantly limited	Moderately limited	Markedly limited	Not able to assess
2. Sustained concentration and persistence					
a. The ability to carry out very short and simple instructions	☐	☐	☐	☐	☐
b. The ability to carry out detailed instructions	☐	☐	☐	☐	☐
c. The ability to maintain attention and concentration for extended periods	☐	☐	☐	☐	☐
d. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances	☐	☐	☐	☐	☐
e. The ability to sustain an ordinary routine without special supervision	☐	☐	☐	☐	☐
f. The ability to work in coordination with, or proximity to, others without being distracted by them	☐	☐	☐	☐	☐
g. The ability to make simple work-related decisions	☐	☐	☐	☐	☐
h. The ability to complete a normal workday without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods	☐	☐	☐	☐	☐
3. Social Interaction					
a. The ability to interact appropriately with the general public	☐	☐	☐	☐	☐
b. The ability to ask simple questions or request assistance	☐	☐	☐	☐	☐
c. The ability to accept instructions and respond appropriately to criticism from supervisors	☐	☐	☐	☐	☐
d. The ability to get along with co-workers without exhibiting behavioural extremes	☐	☐	☐	☐	☐
e. The ability to maintain appropriate behaviour and to adhere to standards of cleanliness	☐	☐	☐	☐	☐

	No limitation	Not significantly limited	Moderately limited	Markedly limited	Not able to assess
4. Adaptation					
a. The ability to respond appropriately to changes at work	☐	☐	☐	☐	☐
b. The ability to be aware of normal hazards and take appropriate precautions	☐	☐	☐	☐	☐
c. The ability to travel in unfamiliar places or use public transportation	☐	☐	☐	☐	☐
d. The ability to set realistic goals or make plans independently	☐	☐	☐	☐	☐

N/A

Section C: Additional Comments on Abilities and/or Restrictions

From the date of this assessment, the above will apply for approximately:

☐ 1–2 days ☐ 8–14 days
☐ 3–7 days ☒ More than 14 days

6 months Postop

Have you discussed return to work with your patient?

☒ Yes
☐ No

Recommendations for work hours and start date:

☒ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start date of return to work: 6 months Postop

Date of next appointment to review abilities and/or restrictions: _____

I have provided this completed Functional Capacity Assessment Form to (check both if applicable):

☐ Employee ☐ Employer

Dr. Lafontaine — 29/11/2021

Health care provider's signature | Telephone | Date

Dr. Robert Lafontaine
Medicine Professional Corporation
D-640 Ross Ave. East
Timmins, Ontario P4N 0A2

From: [redacted]
To: [redacted]
Subject: Fwd: Functional Capacity Form
Date: December 1, 2021 10:35:29 AM

CAUTION - EXTERNAL E-MAIL - Do not click or open attachments unless you recognize the sender.

Sorry, made a mistake on your email the first time i sent.

Stellakh

Sent from my iPad

Begin forwarded message:

> **From:** Stella Kwetachin <stellakh2001@yahoo.ca>
> **Date:** December 1, 2021 at 10:31:28 AM EST
> **To:** ccassidy@sutslegal.on.ca
> **Cc:** cabwetz@sutslegal.on.ca, ballihi@lao.on.ca
> **Subject:** **Functional Capacity Form**
>
> Hi Cameron,
>
> Apparently, Dr. Lafontaine made a mistake on the forms. I had a post op F/U last week and he had agreed that i could go back to work on December 13, 2021, however, i have a second post op F/U on January 12th as he is not too happy that the knee is not bending well enough but hopefully physio will help with this problem. Other then that i am mobile with the assistant of a cane for balance.
>
> I contacted Dr. Lafontaine's office to advise the assistant that FCA Form notes that i am unable to return to work at this time x 6 months post op, i advised her that we had agreed the return date for December 13th, 2021.
>
> Dr. Lafontaine apparently just went on bereavement this week and possibly early next week so the Assistant will try to get Dr. Lafontaine to amend the form upon his return. It may not be until Monday, December 13th, 2021.
>
> Stellakh
>
> Sent from my iPad
>
> Begin forwarded message:
>
> > **From:** "Dr. Lafontaine's Office" <orthocare@eastlink.ca>
> > **Date:** November 30, 2021 at 12:18:38 PM EST
> > **To:** stella[redacted]@yahoo.ca
> > **Subject:** **Emailing: Image.jpg, Image (2).jpg, Image (3).jpg, Image (4).jpg, Image (5).jpg**
> >
> > Good morning, Stella,
> >
> > Here are all the forms filled and signed by Dr. Lafontaine, but your portion
> > isn't completed.
> >
> > Thank you
> >
> > Francine

Desjardins Insurance
LIFE • HEALTH • RETIREMENT

E-MAILED Jan 7/22

GROUP INSURANCE - DISABILITY CLAIMS

SCANNED

STATEMENT OF EARNINGS - DCM

PRINT | NEW REQUEST

Period going from: 2021-12-13 **to:** 2021-12-17

First name & last name of the employee: Stella Kiokee-Koostachin

Policy or group or contract no.: 59086 **Certificate or identification no.:** 63468891

Please indicate the gross earnings for each day worked.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
WEEK 1 FROM: 2021-12-13 TO: 2021-12-17	$202,04	$202,04	$202,04	$202,04	$202,04	$0,00	$0,00
WEEK 2 FROM: TO:							
WEEK 3 FROM: TO:							
WEEK 4 FROM: TO:							
WEEK 5 FROM: TO:							
WEEK 6 FROM: TO:							

COLETTE SHWETZ — **Last name and first name of the authorized person (IN BLOCK LETTERS)**

HR MANAGER — **Position**

Colette Shwetz — **Signature**

Jan 7/22. — **Date**

15082E01 (16-04)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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

SCANNED

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: Stella Kioke-Koostachin | Certificate or identification no. | Social insurance no.*: —

Address of employee - No., street, apt.: P.O Box 152 | City: Attawapiskat | Province: ON | Postal code: P0L 1A0

Telephone no.: ( ) - | E-mail address:

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

Address of policyholder or employer - No., street, suite: 1805 E ARTHUR St., | City: Thunder Bay | Province: ON | Postal code: P7E 2R6

Telephone no.: (807) 622-1413 | Fax no.: ( ) - (YYYY MM DD)

COMPLETE IF SELF-ADMINISTERED: **Effective date of coverage:** **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: ☐ Weekly ☐ Monthly ☒ Every two weeks | Amount: $2020.38

2 Salary effective date (YYYY MM DD): 2021 04 01

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

5 Type of schedule: ☐ Variable ☐ Rotating

6 Premium paid by: ☒ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD): 2006 04 01

8 Occupation: Community Legal Worker

9 Date last worked (YYYY MM DD): 2021 10 05 | No. of hours worked: 3.5

10 Is disability due to an accident? ☐ Yes ☒ No **If "Yes"**, date of accident:

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 %

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 office administration | 35 % **Duties** Customer service (take application) courts | 35 %

Duties travel to communities | 30 % **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 5)	☐	☑	☐
☐ 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 | 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: travel by air, attend remote courts

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

If "Yes", please specify: travel, attending remote courts - sitting, standing, stairs

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Last name and first name of the authorized person (IN BLOCK LETTERS)
COLETTE SHWETZ

Position
HR MANAGER.

E-mail address
cshwetz@manlegal.on.ca.

Signature Colette Shwetz

Date Oct 13/21.

Direction and Authorization Form

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Stella Kicker-Koostachin
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.

Stella Kicker-Koostachin
Signature of Claimant

October 12/21
Date

Employee Statement

Submit online:
desjardinsinsurance.com/en/
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)
Kiekie-Karstachin, Stella	☐ M ☑ F	1966 08 12

Address - No. street, apt	City	Province	Postal code
Box 1532	Attawapiskat	ON	P0L 1A0

Policy or group or contract no.	Division no.	Certificate or identification no.	Social insurance no.[1]
641028			457 013 508

Telephone no. (mandatory): 705 997 2308 ☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]: Stellakk-2001@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.

Cortisone injections

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

Dr. Robert Lafontaine
640 Reed Ave East
Timmins ON P4N 2K3
705 360 5330

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.
Bank of Nova Scotia	002	11012	1820125

Address - No., street, suite	City	Province	Postal code
1 Pine Street South	Timmins	ON	P4N 2J5

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 October 7, 2021. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me

Signature of employee: [signature] Date: October 12/21

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 injury 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.

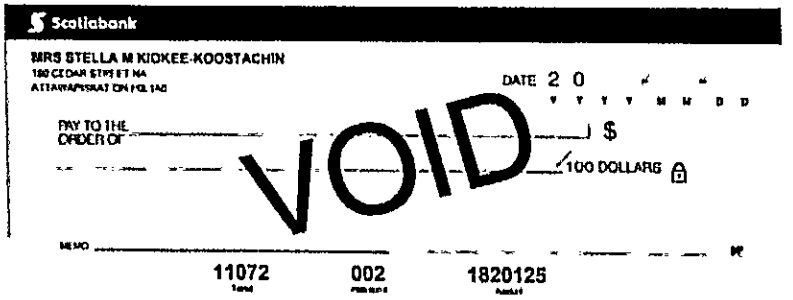
Signature of employee: [signature] Date: October 12/21

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.

Scotiabank®

Void Cheque



Attending Physician Statement

(Please take full package to your physician)

Desjardins
Insurance
Life • Health • Retirement

GROUP INSURANCE DISABILITY CLAIMS

Surgery Later
07/10/2021

IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	Form no. 12018E01
- Musculo-skeletal	Form no. 12019E01
- Psychiatric/psychological	Form no. 12020E01
- Cardiac	Form no. 12021E01
- Cancer	Form no. 12022E01

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571

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

By mail:
PO Box 1223 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-429-6571 (toll free)
416-925-0827
Keep original forms for your records.

Desjardins
Insurance
Life • Health • Retirement

INITIAL ATTENDING PHYSICIAN'S STATEMENT
MUSCULO-SKELETAL FORM

- PLEASE PRINT
- PART 1 to be completed by patient
- PART 2 to be completed by physician
- 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 certificate no.	Certificate or identification no.	Date of birth
641028		

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

1.1 Primary — left knee osteoarthritis

1.2 Secondary

1.3 Date symptoms first appeared: ct, te, 10 ~

1.4 Date patient's disability first prevented them from working: 07/10/2021

1.5 Date of first visit for treatment or consultation: 2021/09

1.6 Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown — If yes, state when and describe:

1.7 Is condition a result of an injury due to an accident? ☐ Yes ☐ No — If yes, please describe:

1.8 Current height — Current weight — Weight loss/gain to date

1.9 Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
If yes, have Worker's Compensation/CNESST forms been completed? ☐ Yes ☐ No

1.10 Date of latest visit: 2021/10/07

1.11 Frequency of visits: ☐ Weekly ☒ Monthly ☐ Other (specify)

1.12 Date of hospital inpatient admission: 2021/10/11 → left total knee replacement

1.13 Date of discharge: 2021/10/11

1.14 Date of hospital outpatient admission:

1.15 Name of hospital: TAPH

1.16 Other treating physicians:

1.17 Pending referrals to specialists:

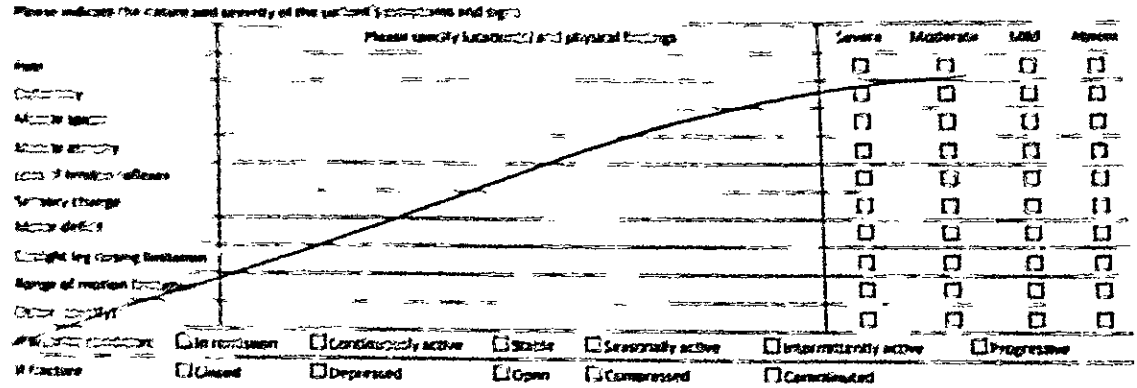
2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results

3. Symptoms and signs

Please indicate the nature and severity of the patient's symptoms and signs



Please specify subjective and physical findings	Severe	Moderate	Mild	Absent
Pain	☐	☐	☐	☐
Deformity	☐	☐	☐	☐
Muscle spasm	☐	☐	☐	☐
Muscle atrophy	☐	☐	☐	☐
Loss of function / disuse	☐	☐	☐	☐
Sensory change	☐	☐	☐	☐
Motor deficit	☐	☐	☐	☐
Straight leg raising limitation	☐	☐	☐	☐
Range of motion limitation	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

Spinal instability: ☐ No instability ☐ Candidate for stability ☐ Stable ☐ Seasonally active ☐ Intermittently active ☐ Progressive

If fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed)

4.2 Physiotherapy (type, frequency, dates)

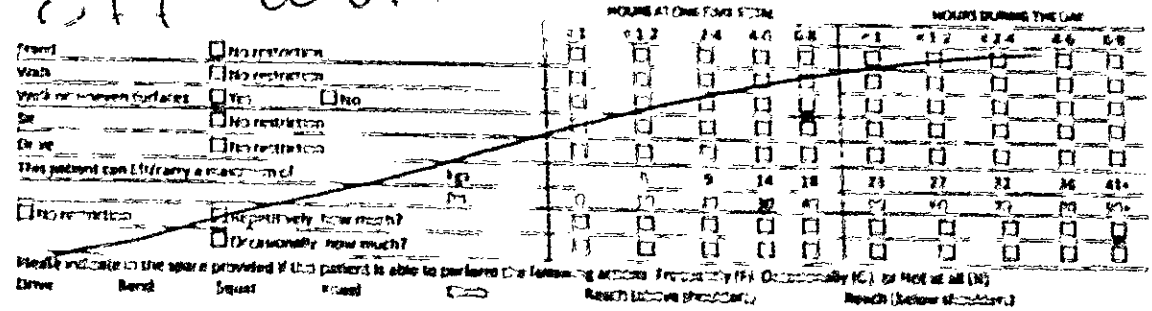
4.3 Surgery date (past) 3 OCT 10 07 Surgery date (future)

4.4 Other treatments

4.5 Is patient compliant with prescribed measures? ☑ Yes ☐ No If no, please explain

5. Restrictions and limitations

off work x 6 month : Post g



		HOURS AT ONE TIME					HOURS DURING THE DAY				
		0-1	1-2	2-4	4-6	6-8	0-1	1-2	2-4	4-6	6-8
5.1	Stand ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.2	Walk ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.3	Walk on uneven surfaces ☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.4	Sit ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.5	Drive ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.6	This patient can lift/carry a maximum of	1kg		5	9	14	18	23	27	32	36	41+
5.7	☐ No restriction ☐ Repetitively, how much? ☐ Occasionally, how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.8	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 shoulder)			Reach (below shoulder)	

6. Prognosis and return to work plans

6.1 Prognosis for recovery Good

6.2 Expected date patient will return to their own occupation 2n 6 month s

6.3 If unknown, please indicate the next follow up date

6.4 If your patient is unable to return to their own occupation please identify when and advise what consequences they could return to modified duties or gradual return to work.

6.5 Have return to work issues been discussed with the patient? ☐ Not ☐ Yes

6.6 Please elaborate on time frames and patient's reaction

7. Progress

7.1 Has patient ☐ Regressed ☐ Improved ☑ Not changed ☐ Retrogressed

7.2 Current status ☐ Satisfactory ☐ Home confined ☐ Bed confined ☐ Hospitalized

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

8.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

8.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

8.3 ☐ Work related issues (please describe if known): _____

8.4 ☐ Substance abuse: _____

8.5 ☐ Other (please describe) _____

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? ☑ Yes ☐ No

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☑ No

If yes to either of the above, 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?

Left total knee
replacement on the
07/10/2021

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): Montcalm, Robert | 11.2 Specialty: | License no.:

11.3 Address - No., street, suite: D 6-46 Kuss Hill East | City: Timmins | Province: ON | Postal code: P4N 0A2

11.4 Telephone no.: (705) 360-5330 | Fax no.: (705) 360-5313

Signature of physician: [signature] | Date: 06 | 10 | 2021

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)
416-926-0657
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
	641028		

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: _____

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: _____

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: Current weight: Weight loss/gain to date

3. Treatment dates

3.1 Date of first visit for current condition: _____

3.2 Date of latest visit: _____

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

3.4 Date of in-patient admission:

3.5 Date of discharge: _____

3.6 Date of out-patient treatment: _____

3.7 Name of hospital: _____

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Surgeries (including dates): _____

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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:

8. Return to work plans

8.1 Prognosis for improvement or recovery: _____
8.2 Expected date patient will return to their own occupation. _____
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: _____

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): LAtontaine, Robert
11.2 Specialty: orthopedic. License no.: 76308
11.3 Address, No., street, suite: 1640 Ross Ave East City: Timmins Province: ON Postal code: P4N 0M2
11.4 Telephone no.: (705) 360-5330 Fax no.: (705) 360 5313
Signature of physician: _____ Date: _____

A

Manulife

Group Benefits
Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1 Plan sponsor statement

Plan sponsor name Nishnawbe-aski Legal Services Plan contract number

Billing division Account/Division number Plan member's certificate number

Do you want the waiting period added to the hire date? ○ Yes ○ No Permanent hire date (dd/mmm/yyyy) 01/APR/2006

Re-hire date (dd/mmm/yyyy) If a re-hire, date previous employment ended (dd/mmm/yyyy)

Occupation Community Legal Worker Class A Hours worked/week 35 Salary $ 45,584 Frequency A

I certify that the **plan member** listed below is **actively** at work at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature Date (dd/mmm/yyyy) 6/Dec/17

Is evidence of insurability required? ○ Yes ✓ No (in order to determine if evidence of insurability is required, please refer to your contract.)

If yes, please complete form GL0004E and send to Manulife for processing.

2 Plan member information

Plan member's last name Kiokee-Koostachin First name Stella

To be completed by employee

Date of birth (dd/mmm/yyyy) 12 08 1966 Gender ○ Male ✓ Female Province of residence ON

Language ✓ English ○ French Do you have a spouse? (married, common law or civil union?) ✓ Yes ○ No

3 Plan member address

Address (number, street, apt.) Box 152

City Attawapiskat Province ON Postal code P0L 1A0

4 For Quebec residents (age 65 or over) Are you participating in the RAMQ drug plan? ○ Yes ○ No

5 Application for coverage

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

I am applying for Extended Health Care for

- ○ Myself only
- ○ Myself and 1 dependant (child or spouse)
- ✓ Myself and 2 or more dependants (spouse and children)
- ○ None, because my spouse has coverage

I am applying for Extended Dental Care for

- ○ Myself only
- ○ Myself and 1 dependant (child or spouse)
- ✓ Myself and 2 or more dependants (spouse and children)
- ○ None, because my spouse has coverage

Are you applying for Dependant Life? ✓ Yes ○ No Dependant Life may be mandatory. Refer to the policy details.

6 Coordination of benefits

This section is required if you are applying for coverage on your dependants.

Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? ○ Yes ✓ No

If yes, please provide the following details: Name of other insurer

Insured's last name Koostachin First name Edward Date of birth (dd/mmm/yyyy) 12/09/1945

Effective date of coverage (dd/mmm/yyyy) 01/02/18 Identification/certificate number Policy number

Please indicate type of coverage under other plan:

In cases where the information is not complete a default value will be applied.

Extended Health Benefits
- ○ Single
- ○ Couple
- ○ Family
- ✓ None

Dental Care
- ○ Single
- ○ Couple
- ○ Family
- ✓ None

Continued on the next page

7 Dependant information

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Spouse

If there is not enough room to list your dependants, attach details on a separate sheet.

Last name Koostachin First name Edward Date of birth (dd/mmm/yyyy) 12/09/65

Gender ☑ Male ○ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy)

**To apply for over-age disabled dependant coverage, please complete form GL0514E.

Last name	First name	Date of birth (dd/mmm/yyyy)	Gender Male	Gender Female	Over-age student	Over-age disabled dependant**
Kiokee	Keifer	27/12/2000	☑	○	○	○
			○	○	○	○
			○	○	○	○
			○	○	○	○

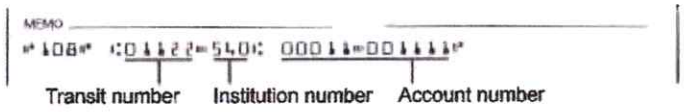
8 Direct deposit

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Transit number 11072

Institution number 002

Bank account number 1820125



Electronic claim statement

By providing your email address, you will receive an invitation to register for an online member account.

Work email address skoostachin@nanlegal.mica Personal email address Stellakk2001@yahoo.ca

9 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative. **I understand and agree** that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember, or from my Plan Sponsor.

Plan member signature Stella Kiokee-Koostachin Date signed (dd/mmm/yyyy) 06/12/64

10 Mailing instructions

Plan Member Administration
Manulife Financial
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8

Manulife

Group Benefits Beneficiary Designation

Please see reverse for assistance in completing this form.

Send the completed form to: **Plan Member Administration**
Manulife Financial
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8
Fax: 1-877-733-4233

All sections of this page should be completed as it will replace any prior designations.

1 Plan member information

Plan sponsor name	Plan contract number	Plan member certificate number
Nishnawbe Aski Legal		
Plan member name (last, first and middle initial)	**Province of residence**	**Date of birth (dd/mmm/yyyy)**
Kiokee-Koostachin Stella	ON	12/08/1966

2 Primary beneficiary

List all primary beneficiaries for Basic Life and/or Basic Accidental Death.

Percentages must total 100% to be valid.

Irrevocability

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
Koostachin	12/09/65	Husband	25 %
Kiokee (Keboker)	05/05/84	Daughter	25 %
Koostachin, Jacob	14/09/87	Son	25 %

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
○ Revocable ○ Irrevocable

3 Optional coverage (if applicable)

Plan contract number

List all beneficiaries for Optional Life and/or Optional Accidental Death.

Irrevocability

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
Koostachin, Mason	20/09/8	Son	25 %
			%
			%

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
○ Revocable ○ Irrevocable

4 Contingent beneficiary

Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member

5 Trustee appointment

Complete if any beneficiary named is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

6 Declaration and authorization

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.

A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:
- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

Plan member signature	Date signed (dd/mmm/yyyy)
Stella Kiokee-Koostachin	06/12/1966