

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.



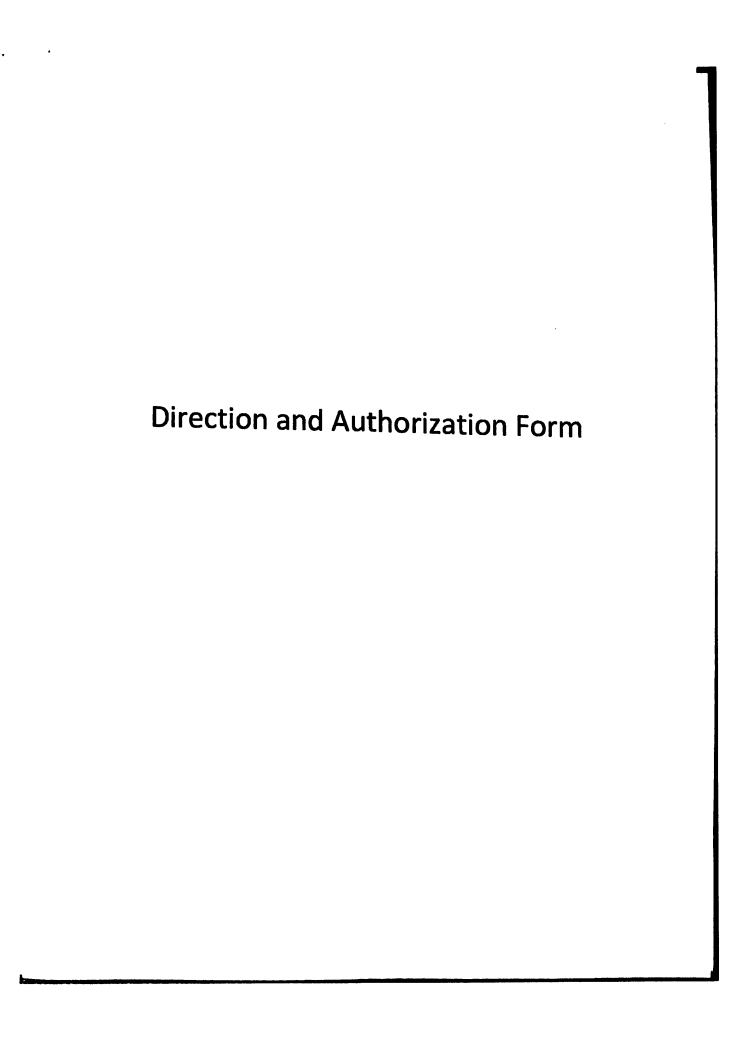
DISABILITY OR WAIVER OF PREMIUM CLAIM

EMPLOYER STATEMENT

GROUP INSURANCE - DISABILITY CLAIMS

Life · Health· Retirement		EMPLOTER STATEMENT
A - IDENTIFICATION We are unable to assess this claim unless all ques	tions are answered completely.	
EMPLOYEE Last name and first name	Certificate or identification no.	Social insurance no.*
Stella Kioke-Koostachin		
Address of employee - No., street, apt. City	Province	e Postal code
P.O Box 152 attawapis	skat of	J POL IAC
Telephone no.: () -	E-mail address:	
POLICYHOLDER OR EMPLOYER Name	Policy or group or contract no.	Division no.
CINUP	641028	
Address of policyholder or employer - No., street, suite City	Provinc	
1805 E ARTHUR St., Thunder	r Bay on	PTE 2R
001	ax no.: ()	
COMPLETE IF SELF-ADMINISTERED: Effective date of coverage:		ss no.:
* Social insurance number is necessary only if the disability claims are taxable.		
B - GENERAL INFORMATION If the benefits are taxable, the basic tax In all other cases, please provide the agents.		
1 Current salary Amount 2	, , ,	ob status
	2021 04 01	Full time Part time
4 Indicate days in normal work week Hours worked 5 Type of schee		by
SUN MON X TUE WED per week	Rotating Employer	Employee Both
A INO XI PRI LISAI 53		
7 Date of employment DD 8 Occupation	9 Date last worked	No. of hours worked
2006 04 01 Community hegal Wa		05 3.5
10 Is disability due to an accident? Yes No If "Yes", date	e of accident:	DD
11 Did or will the employee receive any income during the disability period?	Yes No If "Yes", indica	ate below:
(Type: holiday pay, maternity, disability, El benefits, salary, lump sum, other)		
Type: Ar	mount: \$ 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 X No
13 Has a claim been filed with a government agency? Yes X No If	"Yes", indicate below:	
	Québec only)	
	adebee only)	
Other, specify:		
Date Filed: Decision R		Amount: \$
14 Has the employee returned to work? Yes No If "Yes", on wh	nat date?	
15 Is this person still in your employ? Xes 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	s disability or had an impact on their re	eturn-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)? XYes No	
If so, please indicate the percentage of employment income that is not taxable		

C-	PHYSICAL WORK ENVIRONMENT	Please attach a br	ief job	des	cription	if avai	lable.					
1	What are the main duties of the employee's	s job and how much	time is	allo	cated to							
	Duties office administration		35	%	Duties	Cus	tomer servi	ce (take applic	cation) courts		35	%
	Duties travel to communities		30	%	Duties							%
		For questions 2 ar										
	OCCASIONALLY: 0-15 % of th	e times <u>F</u> REC	UENT	LY:	16-50 %	of the	time	ALWAYS:	51 % + of the time		5.11	
2	Work environment - Does the employee's j	ob require work in a	ny of th	ne fo	llowing co	onditio	ns?					
	FREQUENCY: O F	FREQUEN	ICY:				OFA	FREQUE	NCY:	0	F	<u>A</u>
	Outside	In a damp		mid	environm	ent			below ground level			
	In extremes of cold or heat	☐ Toxic fum				1		Handling	chemicals			Ш
	Does the job involve other hazards?	Yes No	I	f "Ye	s", pleas	se list:						
								-				_
3	Check the items below that relate to the er	nployee's job, and co	mplete	e the	informat	ion rec	quested.					_
40000	FREQUENCY: O F A	FREQU	ENCY:	0	F A		FREC	QUENCY:		0	F	Α
	Standing	Bendin					☐ Exter	nding/reaching	above head	□	\Box	
	☐ Sitting ☐ ☑ ☐	☐ Kneelir			8		√ s	tairs (No. of st		V		
	Keeping one's balance	☐ Crawlin	ng					adders (Height) [
	DESCRIBE ACTIVITY AND SPECIFY FREQUE	NCY AND WEIGHT:						FREQUENC	CY: O F A W	EIGHT:		
	Pushing										b 🗌	_
	Pulling										b 🗌	
	Lifting/carrying									√ L	b □	Kg
	Please list any office equipment, motor vel	nicle, tools or other e	quipm	ent t	hat is use	ed in th	ne employee	e's job.				
	Type of equipment							Times per	day			
	Type of equipment							Times per	dav			
4	Does the employee work in an extremely no	isv environment have	e to wo	rk at	a fast na	ce do	repetitive mo			Yes	П	No
	If "Yes", please specify: travel by air, atte				ш .о.о. ро							
	ii res , piease specify.											
	1											
5	Does the employee's job require dexterity?	Yes	No									
Wall of	If "Yes", please specify: travel, attending			nding	g, stairs							
	If "Yes", please specify:				7 1000000000000000000000000000000000000							
	(-	
D-	ADDITIONAL INFORMATION											
_												
_												
SI	GNATURE OF THE AUTHORIZED PE	RSON										
	st name and first name of the authorized pe	rson (IN BLOCK LE	TTERS	3)				Position HR	MANAC	n=0		
_	LOLETTE SHWETZ mail address		-					110	11 11 1017	メドノ	_,	
E-I	cshwetz@nanlegal	lon.ac.										
Sig	gnature faculte St	49						Date (Det 13/8	2/-		_
	quelle de											



DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM

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

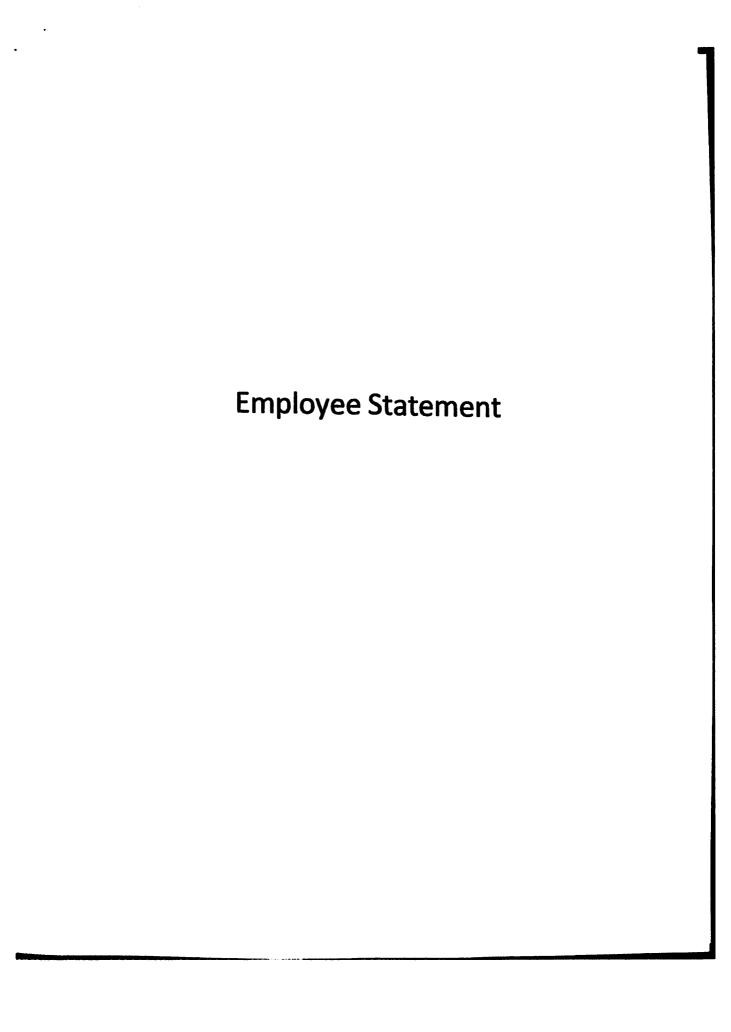
I understand that

- 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.

Signature of Claimant

Date





Submit online:

designations and a design desi 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



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 cla	aim unless all qu	estions are answered	completely.		
Last name and first name of employee	The state of the s		Sex	Date of birth	
Address No. street, apl	St	lla	DMEF	1916	MM DD
Address - No. street, apt	City		Province	Postal	code
Box 150	Hauc	protect	Cru	Pal	100
Policy or group or contract no Division no	Certifica	ate or identification no.	Social insuran	ce no.1	
641028			480	013	-50
Telephone no. (mandatory): (コロットロラーコス	CS VI auf	horize Desjardins Financia	I Security hereinafter Desp	ardins Insurance, to	leave me
E-mail address 2: Stila 14-2001	m wat	SOL CA	ann.		
1 Your social insurance number is necessary only if your disalt	bility claims are ta	vable Please costact	our amployer to obtain t	his information	
² Please provide this information only if you authorize Desjard	ins Insurance to	email you	our amployer to obtain t	ons mornigoon	
B - GENERAL INFORMATION					
1 Training				-	
Level of education					
Work experience					
					-
Spoken language English French	Metter Issues	D			
2 Is disability due to an accident? If "Yes" date of acciden	Written language				
	MM DD	Time	Type of accident		
Yes No		□ AM □ PM	Work-related	Motor vehicle	Other
Indicate details (where, how)					
					_
3 Did you receive prior treatment for the illness or injury cau	ising the disability	7 Yes \ \ No			
If "Yes" give particulars including name address and tele	phone number o	all treating physicians	and specialists		
Contisa lightions					
K					
Name, address and telephone number of physicians and	specialists who h	ave treated you during	the disability		
Dr. Privat 1 - C	\				
640 Ross Aug	Fast				
Timming ICN F		7			
/	The state of the s	65			
(102) 375-23.3	50				

PLEASE COMPLETE THE BACK OF THE FORM.

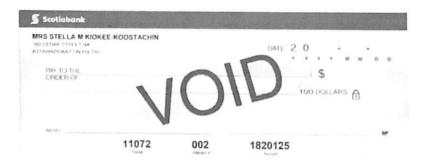
06329E01 (2018-11)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company

If you have any accident or under an individual policy, o	sickness coverage	e through a union, sociarticulars	ciety, credito	r. mortgage.	auto, lod	ige or ot	her ass	ociatio	n, through a	inothe	r empto	yor.
Name of Insurer	Paticy na	Certificate no.	Start date	of benefits	ε	nd date o	of benef	its	Benefit amo	unt W	leekly/M	onthly
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			1717	MM 007	,	1777	MIN		s		Πw	Пм
comments												tamed .
OFFICE REAL PROPERTY.												
- DIRECT DEPOSIT EN		ease include a spec										
hereby authorize Desjardins idicated below	Insurance to depo	sit my benefit paymei	nt through th	B DIRECT	DEPOSIT	f system	into ac	count	at the financ	al ins	titution	
Name of financial institution				tution no.		Transit	/branct	n no.	Acr	count r	20	
Bank of	Doing	Scotia		\sim		1	10	10				5
Address - No., streat, suite			City			Provin				stal co	de	
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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.





Attending Physician Statement

(Please take full package to your physician)

GREEN INSURANCE CHEADILITY CLAIMS



Guisery LITTER Williams

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: desigrdinslifeinsurance.com/send

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

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



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ART 2 - Attending physician's statement	t		
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1.2 Contracting From House		무 무	9
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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 degression, 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 desembe if known)
8.4	□ Substance abuse:
8.5	Other (please describe)
9.	Rehabilitation
9.1	Is patient a suitable candidate for medical rehabilitation services?
9.2	Is patient a suitable candidate for vocation rehabilitation?
	If yes to either of the above, please specify:
	Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?
	Identification of physician
11.	Last name and first name (PLEASE PRINT) 11.2 Specialty License no.
11.	3 Address No., street, suite
_	DELLERST TIMMINS Province Postal code ON PAN OAZ-
11.	4 Telephone no.: (705) 360 - 5330 Fax no. (705) 360 - 5313
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Subsett college destructes l'étimus ente combend Complete and save the form on your computer first Keep original forms for your records.



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



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

O	Desjardins Insurance Life - Heelth - Rettrement		INITI	AL AT	TEN	DING PHYSIC	CIAN'S STATEMENT GENERAL FORM
B PI	LIASE PRINT DART	1 to be completed by	patient				
D P#	-	harge for completion		s the pan	ent's res	ponsibility	
	T 1 - Identification of patient me and first name (PLEASE PRINT)	Policy or grou				ile or identification no	Date of birth
PAR	「2 - Attending physiclan's statemen	it		•			•
It is vo	ry helpful in facilitating a timely comprehensive info	mod adjudication do	cision to hav	e your ful	ll citnical	notes from the date of	disability and any consultation
1. 1.1	Diagnosis (Including complications) - If ps	ychietric, give DS	M-IV code	ermation.			
1.2	Socontary						
	Secondary						
1.3	Subjective symptoms (including severity, frequency,	duration)					
1.4	Findings (please enclose a copy of current # rays, EK						
1 5	Degree of seventy of all symptoms Mild	Moderate	Severe			chatic elements	
2.	History				141111 P24	chair elements	
2.1	Date symptoms hist appeared or accident happened	1					
2.2	Date patient's condition first prevented them from s	working					
2.3	Has this patient ever had same or similar condition? If yes, please specify diagnosis and dates of treating		□No	Ouni	nown		
2.4	Is condition due to injury or sickness arising out of	ahent'i amolowa	.,				
2.5	Have Worker's Compensation/C5ST forms been con	ibleted)	_		□No □No	Unknown	
2.6	If patient is pregnant, give E.D.C		_		LJ.110	Chukuowa	
2.7	Names and specialnes of other treating physicians						
2.8	Current height						
3.	Treatment dates		Cı	illeut we	ght		Weight loss/gain to date
3.1							
3.1	Date of first visit for current condition		3.5 0	ate of dis	scharge		
	Date of latest visit		3.6	ate of ou	t patient	treatment	
3.1	Frequency of wats	ly	3.7 A	tame of t	risnital		·

3.7 Name of hospital. Dother (specify) Outr of in-patient admission Nature of treatment 4.1 Medications (dose, frequency, date prescribed) 4.2 Surgeries (including dates) 4.3 Other(maindingfrequency) 4.4 Is patient fcdowing recommended treatment program?

[] Ye: [] No (please e'aborate) Despirations Insurance refers to Despirations Financial Security Life Assurance Company 13018101 (2018 (3) Page 1 de 2

5.	Progress													
73	Has patient [] Recon Current status [] Ambo	HEON	□ Improved □ House (priñned	Bed confined] Retrogres] Hospital o								
6.	Restrictions and ilmit	ations												
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7.8	Progress with freatment p. Are patient a symptoms re-	wied to dr	ug or alconol apuse?	□res □r	10									
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8.	Return to work plans													
	Progress for improvemen							···						
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8. S	Have return to work time.		discussed with the na	tiant?	·									
8.6	Please elaborate on time !	rames and	patrent's response _		Yes	□ No								
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