

Employer Questionnaire

Employee Name: _____

Policy no. _____

Certificate no.: _____

We've been notified of your employee's medical leave of absence. In order to help the Disability Claims Specialist understand your employee's needs and provide the appropriate resources to facilitate their return to work, we require some additional information from you. Please complete the following questions below and return this form to CINUP as soon as possible. Please note that the information you provide to CINUP/Desjardins is confidential and will not be shared with your employee.

1. Please confirm employee's last physical date worked?

____/____/____
Year/Month/Day

2. Were changes made to the job duties/workload/location/environment prior to the current absence? If not, are such changes expected in the near future?

3. Did you notice any change in their performance or attendance prior to their last day of work? Was this situation discussed with them? What was the employee's reaction?

4. Were there any workplace conflicts or disciplinary action taken in the past few months? If so, please explain.

5. Upon receiving medical clearance, if the employee requires a workplace accommodation such as light duties or partial hours, can you accommodate?

6. Do you have any concerns with regards to this claim or is there any other information you would like considered when the claim is reviewed?

Name of authorized person

Title

Signature

Date