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

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

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

Desjardins Insurance
Life • Health• Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYER STATEMENT

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

EMPLOYEE Last name and first name		Certificate or identification no.	Social insurance no.*
Melanie	Mohan	0063468905	527-329-429

Address of employee - No., street, apt.	City	Province	Postal code
319 Maple Street South	Timmins	Ontario	P4N 1Z5

Telephone no.: (705) 9 8 8 - 0 7 3 6 E-mail address: mmohan@nanlegal.on.ca

POLICYHOLDER OR EMPLOYER Name	Policy or group or contract no.	Division no.
Nishnawbe-Aski Legal Services Corporation	641028	

Address of policyholder or employer - No., street, suite	City	Province	Postal code
1805 Arthur Street East	Thunder Bay	ON	P7E 2R6

Telephone no.: (807) 6 2 2 1 4 1 3 Fax no.: ( ) -

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

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

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

1 Current salary — ☐ Weekly ☐ Monthly ☑ Every two weeks — Amount: $ 2,274.22

2 Salary effective date (YYYY MM DD): 2019-08-19

3 Job status — ☑ Full time ☐ Part time

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

5 Type of schedule — ☐ Variable ☑ Rotating

6 Premium paid by — ☑ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD): 2019-08-19

8 Occupation: Restorative Justice Worker

9 Date last worked (YYYY MM DD): 2019-06-14 — No. of hours worked: 7.00

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

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

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

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

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

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

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

17 Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work?
☐ No ☑ Yes - Please specify: This employee works with vulnerable clients and clients with mental health/substance abuse issues. This can be a high stress position at times.

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

PLEASE COMPLETE THE BACK OF THE FORM.

C - PHYSICAL WORK ENVIRONMENT

Please attach a brief job description if available.

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

Duties		%	Duties		%
Duties	Facilitate Circles	33 %	Duties	Direct Client Support	34 %
Duties	Administrative Duties	33 %	Duties		%

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

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

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

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

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

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

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

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY: O	F	A	WEIGHT:
☐ Pushing N/A	☐	☐	☐	☐ Lb ☐ Kg
☐ Pulling N/A	☐	☐	☐	☐ Lb ☐ Kg
☐ Lifting/carrying N/A	☐	☐	☐	☐ 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
Computer	As needed - many times
Telephone	As needed - many times

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

If "Yes", please specify:

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

If "Yes", please specify:

D - ADDITIONAL INFORMATION

Staff was admitted to hospital.

SIGNATURE OF THE AUTHORIZED PERSON

Colette Shwetz	HR Manager
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
cshwetz@nanlegal.on.ca	
E-mail address	
Colette Shwetz	July 12/23
Signature	**Date**