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: Naveau Shannon | Certificate or identification no.: | Social insurance no.*: 501-603-757

Address of employee - No., street, apt.: 45-630 Riverpark Rd | City: Timmins | Province: Ontario | Postal code: P4P 1B4

Telephone no.: (705) 288-9007 | 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 Arthur St | City: Thunder Bay | Province: Ontario | Postal code:

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

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

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

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

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

2 Salary effective date (YYYY MM DD)

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): 2018-01-29

8 Occupation: Gladue Case Worker

9 Date last worked (YYYY MM DD) | No. of hours worked

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: Shannon works with clients in crisis or have been through trauma. Shannon would need to be able to work in this of environment and be able to assist clients accordingly.

18 Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☑ Yes ☐ No
If so, please indicate the percentage of employment income that is not taxable: 100.00 %

PLEASE COMPLETE THE BACK OF THE FORM.

C - PHYSICAL WORK ENVIRONMENT

Please attach a brief job description if available.

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

Duties _____ % **Duties** _____ %

Duties _____ % **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	☐	☐	☐

FREQUENCY:	O	F	A
☐ In a damp or humid environment	☐	☐	☐
☐ Toxic fume	☐	☐	☐

FREQUENCY:	O	F	A
☐ 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	☐	☐	☐

FREQUENCY:	O	F	A
☐ Bending over	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐

FREQUENCY:	O	F	A
☐ Extending/reaching above head	☐	☐	☐
☐ Climbing	☐	☐	☐
☐ Stairs (No. of steps _____)	☐	☐	☐
☐ 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: _____

_____

_____

_____

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

If "Yes", please specify: _____

_____

_____

D - ADDITIONAL INFORMATION

_____

_____

SIGNATURE OF THE AUTHORIZED PERSON

_____ _____

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

_____

E-mail address

_____ _____

Signature **Date**

SAVE | PRINT | NEW REQUEST