

EMPLOYEE DISABILITY CHECKLIST

Please complete the enclosed forms in full, and in ink. Ensure all forms are signed and dated where applicable.

- o Direction and Authorization Form
- o Employee Statement
- Attending Physician's Statement (take full package to your attending physician who will complete the appropriate form)
- o Void cheque

Mail, fax or email completed forms to:

Mail:

JG Benefits Inc.

1051 King Edward Street Winnipeg, MB R3H 0R4

Fax:

1-833-702-4687

Email:

disability@cinup.ca

Should you have any questions, please contact the CINUP Disability team at 1-800-665-1234



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

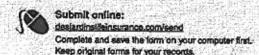
- It is not a requirement of the Policy/Policies that I authorize the company to disclose information to the Policyholder
- This authorization will remain valid for as long as I am claiming benefits or service from the Company: and,
- I am free to revoke this authorization at any time by sending written notice to the Company of such revocation.

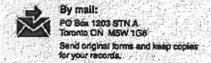
I have read and understand the above. I am signing this voluntarily, and not under compulsion by anyone.

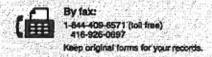
Signature of Claimant

Date

Employee Statement







Contact us: 1-800-263-1810 (toll free) or 416-926-2990

O Desjardins

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM EMPLOYEE STATEMENT

Life - Health - Retirement 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 employed Date of birth OM DE Address - No., street, apt. City Province Postal code Policy or group or contract no. Division no. Certificate or identification no. Social insurance no 641028 I authorize Designdins Financial Security, hereinafter Designdins Insurance, to leave me Telephone no. (mandatory): 14 voicemail about my disability claim. E-mail address : 1 Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information. Please provide this information only if you authorize Desjardins Insurance to email you. **B** - GENERAL INFORMATION 1 Training: Level of education; Shorter. Spoken language: D English French Written language: English French Type of accident is disability due to an accident? If "Yes", date of accident: Time 00 Work-related Motor vehicle Other Ves Yes ☐ No **DPM** 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; THE CHANGE [4] Name, address and telephone number of physicians and specialists who have treated you during the disability.

PLEASE COMPLETE THE BACK OF THE FORM.

06329E01 (2018-11)

Designations Insurance refers to Designations Financial Security Life Assurance Company.

B - GENERAL INFORMAT	пои (соптиц	JED)	20.		
5 If you have any accident o under an individual policy,	r sickness coverag	ge through a union, so	ociety, creditor, mortgage,	auto, lodge or other association	on, through another employer,
Name of Insurer	Polley no.	Certificate no.	Start date of benefits	End date of benefits	Benefit amount Weskly/Monthi
	CARROLLAN	THE PARTY OF THE	mir da co	Tref NM 00	s □w □м
			'mm' iei leb	7777 New 00	90.000.000.000
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Comments: 0					
				100000000000000000000000000000000000000	9
				THE PART OF THE PA	mai prome
		111 - 1987 100 1147 - 1174 11			
C - DIRECT DEPOSIT EN	BOLMENT P	lease include a spec	imen cheque marked "	VOID"	
I hereby authorize Desjardins					at the finencial lostitution
indicated below:	imposition to copy	wir und neutebilt berkrine	in anough the Dute of D	Er Con System (I III) BOOGUL C	K THE INITIAL MISSION OF
Name of financial Institution		A.c.	Institution no.	Transit/branch no.	Accounting.
iaise Voor	aloure.	Hlonor	890	13392	
Address - No., street, suite			City	Province	Postal code
45 Mount	ω 1 ω 0	rtn -	Timmin	z On	LAN SHL
Any credit entered in my acco				DIRECT DEPOSIT transaction	code and I acknowledge that
the credit in question shall cor	istitute an amount	paid in accordance v	with this authorization.		
This authorization will be effect				. The authorization will	terminate following a 10-day
written notice by either Desjar	dins insurance or	me.)	-	Ka 2000
Signature of employee:	MOU	ada t	saul_	Date:	to and
		7777)
D - PERSONAL INFORMA	and an interest of the second	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW			
					s information on file so that you
					rance employees who need to rmational purposes. Desjardins
Insurance may also communic	cate with plan mer	nbers to provide then	with optimal health man	agement. You have the right to	consult your file. You may also
					it send a written request to the nsurance may use the client lis
to offer its clients an insurance	product following	the termination of the	sir group insurance. If you	do not wish to receive these of	
removed from the list. To do so	, you must send a	written request to the	e Privacy Officer at Desja	mins Insurance.	
ورالالتحالية كالمساورة والمساورة والمراكزة	out - printern telephonomic-en-	na kowesi - wiliya	The state of the s		
E - DECLARATION AND A	AUTHORIZATIO	N FOR THE COLL	ECTION AND COMMU	INICATION OF PERSONA	LINFORMATION
		To be co	ompleted for each claim		18 VINCES
I hereby certify that the above	answers are full a	nd true. I authorize De	siardins insurance strictly	for the purposes of determining	og my insurability, managing my
file and settling my claims to: (a) collect from any	person or legal entity	y, or from any public or pa	rapublic organization, only the	information deemed necessary
to manage my file. The non-ext known as Medical Information	naustive list of sou Bureau), insurance	e companies, persona	mation may be collected in al information officers or in	restigation agencies, the polic	s or raculues, the Mib (former) yholder, my employer or forme
employers: (b) communicate to	the said persons of	r organizations only th	e personal information ab	out me that is deemed necessa	ry for the purposes of my file: (c
when necessary request an in					
Provided that I have filled out I Desjardins insurance permission	ne appropriate bo on to leave volcem	xes, I aumonze Desja ali about my disability	claim at the phone number	ne at the address provided in t or provided on this form.	section A of this form and I give
					ization is as valid as the original
	1.2.0	1/2/2	1-1-	and the same of th	18 2023
Signature of employee:	THYON	VIII KV	111 7	Date: \\ \ \ \	VIX UNT

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.

Attending Physician Statement

(Please take full package to your physician)

GROUP INSURANCE - DISABILITY CLAIMS



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: desiardinslifeinsurance.com/send

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

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



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



By mall: PO Box 1203 STN A Toronto ON MSW 136 Send original forms and keep copies for your records.



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

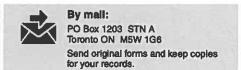


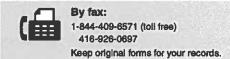
INITIAL ATTENDING PHYSICIAN'S STATEMENT

	Life - Health - Retirement		GENERAL FORM
0	PLEASE PRINT.	PART I to be completed by patient.	
=	PART Z to be completed by physician.	Any charge for completion of this form is the patie	ent's responsibility.
PAI	T1 - Identification of patie	그렇게 하다가 살아가 그 그들은 어린이 되는 그들은 맛이 되었다. 그런 그렇게 하는 것이 없어 없어 없어요?	
34.	name and first name (PLEASE PRINT)		Certificate or identification no. Date of birth
	131 - 141 SECONDO DE TENENTO DE LA CONTRACTOR DE LA CONTR	641028	YAY WW SE
PAI	RT 2 - Attending physician's	statement	Little of the Live of
It is v	ery helpful in facilitating a timely compre	e francisco de la compaño d	clinical notes from the date of disability and any consultation
1.		ons) - If psychiatric, give DSM-IV code.	Dietasan bergeleh d
Ll	W 11 - 1	record of the engineer were set, the management of the there is	er ture Pelvie frecture
1.2	secondary: longue loc		transcript home injudy
.1.3	lace of by Lence	try decreased chilly	er Dard mouth tanger poin
1.5		int x-rays, ExGs, laboratory data; blood pressure and any ot	ther relevant clinical findings): Click Cock Cock Cock Cock Cock Cock Cock Co
2.	History		
2.1	entities agon it decreased a rest of the	POEO STORE THE PROPERTY OF THE	and the factor of the second
2.2	Date patient's condition first prevented		mplaced
2.3			
	if yes, please specify diagnosis and date	s of treatment:	
2.4	is condition due to injury or sickness an	sing out of patient's employments?	No. Division
2.5	Have Worker's Compensation/CSST form		No Bunknown
2.6	If patient is pregnant, give E.D.C.:	7770 And 55	No Bunknown Dr Cohen Reych
2.7	Names and specialties of other treating	physicians as Male (Marks Singe	Bri You (Richard, Mulhar Maria 1)
2.8	Current height: 19(2	Current weight	Weight loss/gain to date:
3.	Treatment dates		
3,1	Date of first visit for current condition:	ZORT QT Q5 3.5 Date of dischar	rge: TrB Line 50
3.2	Date of latest visit:	3.6 Date of out-part	ident treatment:Still colora Heck.
3.3	Frequency of visits: Weekly	Monthly 3.7 Name of hospit	nal: CHEO ·
3.4		20 to 50	
4	Nature of treatment	Przejsky okoly o roki Kultoka i	HEURSALDIFICEÄTAKKEN SIGN TOIL
	Allowed the control of the control o	cribed: My Hyll analyesics,	and the a bluebox
4.1	Medications (dose, frequency, date pres	pribed): 1 on 11 (1 or control)	Programme Contraction
4.2	Surgeries (including dates):OCIE	fearing bly 5th would	+1) July 5 710 1210 18
4,3	Other [bicluding frequency]:	3. iopowich duly	4
4.4	Is patient following recommended treat	ment program? Yes _ DNo (please elaborate):	

5.	Progress							
5.1 5.2	THE INDITION THE PROPERTY TO T							
6.	Restrictions and limitations							
HOURS AT ONE TIME TOTAL HOURS DU								
	\$1 \$1-2 \$2-4 4-5 5-8 \$1 \$1 \$1-2 \$2.4 A.E. 5.9							
6.1	Stand No restriction							
6.3	Wolf to represent the first test and the first test and t							
6.4								
6.5								
6.6	This patient can lift/carry a maximum of: kgs 0 5 9 14 18 23 27 32 36 41+							
	ibs 0 50 20 30 40 50 60 70 80 90+							
6.7	No restriction Repetitively: 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: likely to be affected by regulate of event							
7.2	Precipitating chronological events: — — — — — — — — — — — — — — — — — — —							
7.3	Work issue related to this illness: ACGNC((C G)							
7.4	Pre-morbid personality:							
7.5	Changes in ADL habits:							
7.6	Familial risk factors:							
7.7	Progress with treatment plan:							
7.8								
7.9:	Has your patient ever been enrolled in a substance abuse program? No If yes, state when:							
8.	Return to work plans							
8.1	Prognasis for improvement or recovery: + Cit Wagne(c)							
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. cardioquimonary program, speech therapy, etc.):							
	If yes, please specify: Duy (ICC) Relichtitates - extencive regulary .							
9.2	Is patient a suitable candidate for vocation rehabilitation? Yes No If yes, please specify:							
10.	Comments							
4 144	Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment regulrements?							
	Vera clivel included that will give us a better timberstanding or your partient's condition or treatment requirements?							
•	Mensotrus not cost merchant benounted Dite. 121 to							
	love ten dudit							
TA.								
	Identification of physician							
	Last name and first pame (PLEASE PRINT) 11.2 Specialty License no. 707							
11.3	Address. No. street suite - 401 Court Rd. Others ON KIHELI.							
11.4	Telephone no.: (6 (7) 727 - 7600 x 5267 Fax no.: (6 (7) 738 - 4840							
Signa	ture of physician: Date: \$1427.7073							









GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM EMPLOYER STATEMENT

MPLOYEE Last name and first name		Certificate or ide	ntification no.	Social insura	nce no.*
Ratte, Amanda				540	-204-864
ddress of employee - No., street, apt.	City		Province		Postal code
5-4133 Hwy 101 West	Timmins		ON		P4R 0E7
elephone no.: (705) 4 6 5 = 6 2 2 2		E-mail address:	aratt	e@nanlegal.o	n.ca
OLICYHOLDER OR EMPLOYER Name		Policy or group	or contract no.	Division no.	
CINUP	da i	64	1028		
ddress of policyholder or employer - No., street, suite	City		Province		Postal code
elephone no.: ()	Fa	ax no.:) -		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		YYY MM	DD		105111111111111111111111111111111111111
OMPLETE IF SELF-ADMINISTERED: Effective date of cover			Class	s no.:	
Social insurance number is necessary only if the disability claims	are taxable.				
- GENERAL INFORMATION If the benefits are taxable	, the basic tax	deductions will	oe made.		
m an other cases, prease		propriate tax for Salary effective	alasa lab	status	
	(E)	YYYY MM	DD G		¬
Weekly Monthly ✓ Every two weeks \$ 2,143		2021-0		Full time	Part time
Indicate days in normal work week Hours worked SUN MON TUE W WED per week	Type of sched	dule	6 Premium paid by	/	
☑ THU ☑ FRI ☐ SAT 35.00	Variable	Rotating	✓ Employer	Employe	e Both
Date of employment 8 Occupation		9 0	ate last worked		of hours worked
2 0 2 1 - 0 4 - 2 6 Indigenous Bail Verification	Worker	2	0 2 3 - 0 7 -	0 3	7.00
Is disability due to an accident? Yes Vo	44 HV60 -1-4-		YYYY MM	DD	7.00
	If "Yes", date	or accident:			
Did or will the employee receive any income during the disability		Yes ✓ No	if "Yes", indicate	e below:	
(Type: holiday pay, maternity, disability, El benefits, salary, lump			marks 4		
Type:		nount: \$	Period:		
If the employee is pregnant, has an application for a preventive w	ithdrawal been,	or will it be, subm	tted to the CNESST (Québec only)?	Yes 🗸
Has a claim been filed with a government agency?	V No If "	' Yes" , indicate be	ow:		
CNESST/WCB/WSIB/WHSCC CPP/QPP	SAAQ (C	Québec only)			
Other, specify:					
Date Filed:	Decision Re	andered:		Amount: \$	
\$ 		Υ	YY MM DD	Amount. 4	<u>-</u>
Has the employee returned to work? Yes No	if "Yes", on wh	at date?	DD		
Is this person still in your employ? Yes No - Termin	nation date:	TIII MANA	Reason:		
Was this person given a record of employment?	√ No				
Are there any work-related factors that may have contributed to	the employee's	disability or had a	n impact on their retu	rn-to-work?	
▼ No Yes - Please specify:	-				

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 Bail Intake and court attendance 35 % Duties Administrative Duties - file and database	15 %
_	Dutles Supervision and follow up with clients 25 % Dutles Outreach	25 %
W	For questions 2 and 3, <u>FREQUENCY</u> is defined as follows: QCCASIONALLY: 0-15 % of the times <u>F</u> REQUENTLY: 16-50 % of the time <u>A</u> LWAYS: 51 % + of the time	
2	Work environment - Does the employee's job require work in any of the following conditions?	
	FREQUENCY: O F A FREQUENCY: O F A FREQUENCY:	OFA
	Outside	
	In extremes of cold or heat ☐ ☐ ☐ Toxic fume ☐ ☐ ☐ 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 FREQUENCY: O F A FREQUENCY: Standing Standing FREQUENCY: O F A FREQUENCY: FREQUENC	0 F A
	☑ Walking ☐ ☐ ☐ Climbing	888
	Sitting Crouching Stairs (No. of steps) Keeping one's balance Crawling Crawli	
	DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT: FREQUENCY: O F A WEIGHT	HT:
		LbKg
	Pushing	Шы Шка
		— Си Пка
	Lifting/carrying paper files	
	Type of equipment Times per day	
	Top of a submont	
(43)	Type of equipment Times per day	7. [7].
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	
۳	If "Yes", please specify: Need to write, type and use smart phone	
	n "Yes", please specify:	
D -	ADDITIONAL INFORMATION	
_		
SIC	GNATURE OF THE AUTHORIZED PERSON	
	wetz, Colette HR Manager t name and first name of the authorized person (IN BLOCK LETTERS) Position	
	nwetz@nanlegal.on.ca	
_	nall address liable 2m au 9/2	
Slg	nature Date	<u> </u>