CINUP
Employee
Benefits
for First Nations

EMPLOYEE DISABILITY CHECKLIST

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

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

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Amanda Ratté
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.

Amanda Ratté
Signature of Claimant

July 18/2023
Date

Employee Statement

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.

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

Desjardins Insurance
Life · Health · Retirement

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 claim unless all questions are answered completely.

Last name and first name of employee	Sex	Date of birth (YYYY MM DD)
Amanda Ratte	☐ M ☑ F	1993 04 13

Address - No., street, apt.	City	Province	Postal code
15-4133 hwy 101 West	Timmins	ON	P4R 0E7

Policy or group or contract no.	Division no.	Certificate or identification no.	Social insurance no.[1]
641028			540 204 864

Telephone no. (mandatory): 705 1465 -6222 ☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]:

[1] Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
[2] Please provide this information only if you authorize Desjardins Insurance to email you.

B - GENERAL INFORMATION

1. Training: Full training
   Level of education: Social work
   Work experience: Jubilee Centre, Living Space, Woman Shelter, Nan legal
   Spoken language: ☑ English ☐ French Written language: ☑ English ☐ French

2. Is disability due to an accident? ☑ Yes ☐ No If "Yes", date of accident: (YYYY MM DD) 2023 07 04 Time: 738 ☐ AM ☑ PM Type of accident: ☐ Work-related ☐ Motor vehicle ☑ Other Water craft
   Indicate details (where, how):
   Watercraft incident in dads care, Kaiden hit a parked boat with the seadoo. He is in icu in Critical care Multiple fractures and laserations to his body, broken Femur (right) Major dental work/plastic surgery

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:
   ~~Timmins hos~~

4. Name, address and telephone number of physicians and specialists who have treated you during the disability:
   Timmins hospital 700 Ross ave E, CHEO Ottawa hospital 401 Smyth rd, (See attached documents, too many to list!)

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

B - GENERAL INFORMATION (CONTINUED)

5 If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Start date of benefits YYYY MM DD	End date of benefits YYYY MM DD	Benefit amount	Weekly/Monthly
					$	☐ W ☐ M
					$	☐ W ☐ M

Comments: NO

C - DIRECT DEPOSIT ENROLMENT

Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution	Institution no.	Transit/branch no.	Account no.
Caisse Populaire Alliance	890	13392	0270645

Address - No., street, suite	City	Province	Postal code
45 Mountjoy North	Timmins	ON	P4N 8H7

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: Amanda Ratte **Date:** July 18 2023

D - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I hereby certify that the above answers are full and true. I authorize Desjardins Insurance strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Signature of employee: Amanda Ratte **Date:** July 18 2023

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)

Desjardins
Insurance
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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: desjardinslifeinsurance.com/send

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

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

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

INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

A PLEASE PRINT.
C PART 2 to be completed by physician.
D PART 1 to be completed by patient.
O Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
	641028		YYYY MM DD

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.

1.1 Primary: Multi-system trauma. Femur fracture. Pelvic fracture. Severe soft tissue loss and injury to Right thigh.

1.2 Secondary: Tongue laceration. Dental injury, traumatic brain injury, Fingertip laceration, nasal fracture requiring reduction.

1.3 Subjective symptoms (including severity, frequency, duration): Constant tearful mouth/tongue pain. Lack of leg function, decreased ch. Unable to eat and talk.

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings): X-rays as attached, open reduction internal fixation, blood work and vitals

1.5 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☒ Severe ☐ With psychotic elements

2. History

2.1 Date symptoms first appeared or accident happened: 2023 07 04

2.2 Date patient's condition first prevented them from working: Child, not employed

2.3 Has this patient ever had same or similar condition? ☐ Yes ☒ No ☐ Unknown

if yes, please specify diagnosis and dates of treatment:

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☒ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☒ Unknown

2.6 If patient is pregnant, give E.D.C.: YYYY MM DD N/A

2.7 Names and specialties of other treating physicians: Dr. Cohen (Psych), Dr. McIlquham (Plastic Surgery), Dr. Scott-Conner, Cell (Orthopaedic Surgery), Dr. Vaccani (ENT), Dr. Excelsior (Anesthesiology), Dr. Yan (Plastics), Multiple TC's and ID doc

2.8 Current height: 142 cm. Current weight: 32.7 kg. Weight loss/gain to date: ?

3. Treatment dates

3.1 Date of first visit for current condition: 2023 07 05

3.2 Date of latest visit: Still admitted

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☒ Other (specify): Still admitted

3.4 Date of in-patient admission: 2023 07 05

3.5 Date of discharge: TBD YYYY MM DD

3.6 Date of out-patient treatment: Still admitted.

3.7 Name of hospital: CHEO.

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): Multiple analgesics, multiple antibiotics,

4.2 Surgeries (including dates): ORIF femur July 5th, Wound I+D July 5, 7, 10, 12, 15, 18. Skin graft July 21, Vacuum change July 21, Bentil July 26, March 14, 17.

4.3 Other (including frequency): Ex. Laparotomy July 7.

4.4 Is patient following recommended treatment program? ☒ Yes ☐ No (please elaborate):

5. Progress

5.1 Has patient: ☐ Recovered ☒ Improved ☐ Not improved ☐ Retrogressed
5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☒ Hospital confined – not discharged yet

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			<1	<1-2	<2-4	4-6	6-8	<1	<1-2	<2-4	4-6	6-8
6.1	Stand	☐ No restriction	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☐ No restriction	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☐ Yes ☐ No	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☐ No restriction	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction N/A.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of: kgs		0	5	9	14	18	23	27	32	36	41+
	lbs		0	(5)	10	20	30	40	50	60	70	80	90+
6.7	☐ No restriction	☐ Repetitively: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally: 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: N Bend: O Squat: N Kneel: N Climb: N Reach (above shoulders): O Reach (below shoulder): O.

7. Psychiatric illness (if applicable)

7.1 History: likely to be affected by magnitude of event
7.2 Precipitating chronological events: cannot know at a given degree yet.
7.3 Work issue related to this illness:
7.4 Pre-morbid personality:
7.5 Changes in ADL habits:
7.6 Familial risk factors:
7.7 Progress with treatment plan:
7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☐ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility:
7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when: YYYY MM DD

8. Return to work plans

8.1 Prognosis for improvement or recovery: fair prognosis
8.2 Expected date patient will return to their own occupation: N/A.
8.3 If unknown, please indicate the next follow up date: YYYY MM DD
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. cardiopulmonary program, speech therapy, etc): ☒ Yes ☐ No
If yes, please specify: Physical Rehabilitation - extensive required.
9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify:

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?
Very severe injury requiring significant treatment interventions, not yet recorded/recovered. Potential for long term disability

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): Tice, Andrew
11.2 Specialty: Orthopedic Surgery
License no.: 95797
11.3 Address - No., street, suite: CHEO - 401 Smyth Rd. City: Ottawa Province: ON Postal code: K1H 8L1.
11.4 Telephone no.: (613) 737-7600 x 3267 Fax no.: (613) 738-4840
Signature of physician: Date: July 27, 2023

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.*
Ratte, Amanda		540-204-864

Address of employee - No., street, apt.	City	Province	Postal code
15-4133 Hwy 101 West	Timmins	ON	P4R 0E7

Telephone no.: (705) 4 6 5 - 6 2 2 2 E-mail address: aratte@nanlegal.on.ca

POLICYHOLDER OR EMPLOYER Name	Policy or group or contract no.	Division no.
CINUP	641028	

Address of policyholder or employer - No., street, suite	City	Province	Postal code

Telephone no.: ( ) - 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: $ 2,143.40
☐ Weekly ☐ Monthly ☑ Every two weeks

2 Salary effective date (YYYY MM DD): 2021-04-26

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): 2021-04-26

8 Occupation: Indigenous Bail Verification Worker

9 Date last worked (YYYY MM DD): 2023-07-03
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:

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	Bail Intake and court attendance	35 %	**Duties**	Administrative Duties - file and database	15 %
Duties	Supervision and follow up with clients	25 %	**Duties**	Outreach	25 %

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	☐	☐	☐		☐ Lb ☐ Kg
☐ Pulling	☐	☐	☐		☐ Lb ☐ Kg
☑ Lifting/carrying paper files	☑	☐	☐	5	☑ 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: Need to write, type and use smart phone

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Shwetz, Colette	HR Manager
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
cshwetz@nanlegal.on.ca	
E-mail address	
Signature	Date: Aug 9/23