Direction and Authorization Form

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Cheryl Suggashie
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]
Signature of Claimant

July 29 2024
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:
1-844-409-8571 (toll free)
416-926-0897
Keep original forms for your records.

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

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: Suggashie Cheryl

Sex: ☐ M ☑ F

Date of birth (YYYY MM DD): 1980 12 12

Address - No., street, apt.: 733 Confederation Drive

City: Thunder Bay

Province: ON

Postal code: P7E 3N5

Policy or group or contract no.: 641028

Division no.:

Certificate or identification no.:

Social insurance no.[1]: 511 702 678

Telephone no. (mandatory): (807) 355 - 0341

☑ 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:

Level of education: Masters in Social Justice

Work experience: 3+ years

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):

Time: ☐ AM ☐ PM

Type of accident: ☐ Work-related ☐ Motor vehicle ☐ Other

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.

4. Name, address and telephone number of physicians and specialists who have treated you during the disability:

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: ______________________________

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.
TD Bank	004	06632	6546711

Address - No., street, suite	City	Province	Postal code
595 Arthur Street West	Thunder Bay	Ontario	P7E 5R5

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 July 29 2024. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: [signature] **Date:** July 29 2024

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: [signature] **Date:** July 29 2024

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.

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.

INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

- A PLEASE PRINT
- B PART 1 to be completed by patient
- C PART 2 to be completed by physician
- D 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		

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: Generalized Anxiety Disorder

1.2 Secondary:

1.3 Subjective symptoms (including severity, frequency, duration): constant worry, nausea, muscle tension, insomnia, concentration issues

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):

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: April 2024

2.2 Date patient's condition first prevented them from working: July 21 2024

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.:

2.7 Names and specialties of other treating physicians:

2.8 Current height: ER visit July 21 2024 Current weight: Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: ~~July 2024~~

3.2 Date of latest visit: July 29 2024

3.3 Frequency of visits: ☐ Weekly ☑ Monthly ☐ Other (specify): planned reassess monthly

3.4 Date of in-patient admission:

3.5 Date of discharge: July 22 2024

3.6 Date of out patient treatment: July 24 2024

3.7 Name of hospital:

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed):

4.2 Surgeries (including dates):

4.3 Other (including frequency): psychotherapy weekly x 8 wks

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

5. Progress

5.1 Has patient ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

5.2 Current status ☒ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	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: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulder):

7. Psychiatric illness (if applicable)

7.1 History: See prior page

7.2 Precipitating chronological events: work stress

7.3 Work issue related to this illness:

7.4 Pre-morbid personality: Ø

7.5 Changes in ADL habits: Ø

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:

8. Return to work plans

8.1 Prognosis for improvement or recovery: Good

8.2 Expected date patient will return to their own occupation: Sept 29 2021

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. cardiopulmonary program, speech therapy, etc) ☐ Yes ☒ No
If yes, please specify:

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?

Psychotherapy weekly & Enfis T/c for return to work week 6-8

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) License no.

11.3 Address - No., street, suite Province Postal code

11.4 Telephone no.: ( )

Dr.Mario Nucci
Algoma Place Health Centre
153 S. Algoma ST. Thunder Bay, ON, P7B 3B7
Ph. (807) 345-5020 Fax (807) 345-2783
Practitioner # 103595

Signature of physician: [signature] Date: July 29 21

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.

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: Suggashie Cheryl
Certificate or identification no.:
Social insurance no.*: 511-702-078

Address of employee - No., street, apt.: 733 Confederation Drive
City: Thunder Bay, Ontario
Province: ON
Postal code: P7N 3N5

Telephone no.: (807) 3 5 5 - 0 3 4 1
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:
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: ☐ Weekly ☐ Monthly ☑ Every two weeks — Amount: $ 2,508.57
2. Salary effective date (YYYY MM DD): 2 0 2 0 - 1 0 - 2 6
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): 2 0 2 0 - 1 0 - 2 6
8. Occupation: Publice Legal Education - Communications Lead
9. Date last worked (YYYY MM DD): 2 0 2 4 - 0 7 - 1 9 — 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: Sick Leave **Amount:** $ 1,254.29 **Period:** July 22 - July 26
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:** **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: 100.00 %

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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	%
Carrying boxes, presentation equipment	30 %	Administrative duties (emails, files, etc)	30 %
Traveling to communities	20 %	Resourcing Information and delivering presentations	20 %

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:

Activity	Description	O	F	A	WEIGHT:
☑ Pushing	Boxes of presenation materials - pushing dolly	☐	☑	☐	50 ☑ Lb ☐ Kg
☐ Pulling		☐	☐	☐	☐ Lb ☐ Kg
☑ Lifting/carrying	Lifting boxes of resources and brochures. Setting up tables. Assemly of Canopes and display	☐	☐	☑	100 ☑ 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, keyboard	all day
furniture dolly	up to 1 and sometimes more

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: This employee travels to provide legal education to fly-in communities regularly. This can be fast paced.

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

If "Yes", please specify: This position can be physical at times when delivering education presentations to the remote communities. Cheryl must bring everything with her for the presentations.

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Shwetz, Colette.
Last name and first name of the authorized person (IN BLOCK LETTERS)

Director of HR.
Position

cshwetz@nanlegal.on.ca.
E-mail address

[signature]
Signature

July 31/24.
Date