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Toronto ON M5W 1G6Send original forms and keep copies  
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416-926-0697

Keep original forms for your records.

**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.

<b>EMPLOYEE</b> Last name and first name Zoccole Terri	Certificate or identification no. 0063468943	Social insurance no.* 481-739-712
Address of employee - No., street, apt. 421 York Street	City Thunder Bay	Province ON
		Postal code P7A 7S1
Telephone no.: ( 807 ) 2 8 6 - 8 1 3 1	E-mail address: tzoccole@nanlegal.on.ca	
<b>POLICYHOLDER OR EMPLOYER</b> Name Nishnawbe-Aski Legal Services Corporation	Policy or group or contract no. 641028	Division no.
Address of policyholder or employer - No., street, suite 101 Syndicate Ave. North, Suite 101	City Thunder Bay	Province ON
		Postal code P7B 2V3
Telephone no.: ( 807 ) 6 3 3 - 1 4 1 3	Fax no.: ( )	
	YYYY MM DD	
<b>COMPLETE IF SELF-ADMINISTERED:</b> Effective date of coverage:	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.

<b>1</b> Current salary <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> Every two weeks Amount \$ 2,093.00	<b>2</b> Salary effective date YYYY MM DD 2 0 1 7 - 1 0 - 1 0	<b>3</b> Job status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time
<b>4</b> Indicate days in normal work week <input type="checkbox"/> SUN <input checked="" type="checkbox"/> MON <input checked="" type="checkbox"/> TUE <input checked="" type="checkbox"/> WED <input checked="" type="checkbox"/> THU <input checked="" type="checkbox"/> FRI <input type="checkbox"/> SAT Hours worked per week 35.00	<b>5</b> Type of schedule <input checked="" type="checkbox"/> Variable <input type="checkbox"/> Rotating	<b>6</b> Premium paid by <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> Both
<b>7</b> Date of employment YYYY MM DD 2 0 1 7 - 1 0 - 1 0	<b>8</b> Occupation Gladue Case Worker Lead	<b>9</b> Date last worked YYYY MM DD 2 0 2 4 - 0 3 - 0 8 No. of hours worked 7.00
<b>10</b> Is disability due to an accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", date of accident:		
<b>11</b> Did or will the employee receive any income during the disability period? (Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other) Type: Amount: \$ Period:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", indicate below:	
<b>12</b> If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (Québec only)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>13</b> Has a claim been filed with a government agency? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", indicate below: <input type="checkbox"/> CNESST / WCB / WSIB / WHSCC <input type="checkbox"/> CPP / QPP <input type="checkbox"/> SAAQ (Québec only) <input type="checkbox"/> Other, specify: _____ YYYY MM DD		
<b>14</b> Has the employee returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", on what date: YYYY MM DD		
<b>15</b> Is this person still in your employ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No - Termination date: YYYY MM DD Reason:		
<b>16</b> Was this person given a record of employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>17</b> Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Please specify: _____		
<b>18</b> Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 Attend court and assist Gladue clients (care plans) 25 % Duties Administrative Support 30 %  
 Duties Provide support to Gladue Writers 25 % Duties Travel (to courts, see clients and to office) 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?

<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>
<input type="checkbox"/> Outside	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In a damp or humid environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Above or below ground level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In extremes of cold or heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Toxic fume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Handling chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>
<input type="checkbox"/> Standing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending over	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Extending/reaching above head	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Stairs (No. of steps <u>1</u> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keeping one's balance	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ladders (Height _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:

<input type="checkbox"/> Pushing <u>None</u>	<b>FREQUENCY:</b>	<b>O</b>	<b>F</b>	<b>A</b>	<b>WEIGHT:</b>	<input type="checkbox"/> Lb	<input type="checkbox"/> Kg
<input type="checkbox"/> Pulling <u>None</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Lifting/carrying <u>Sometimes lifting files, boxes, etc</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment	Computer Laptop, Cell phone	Times per day	30
Type of equipment	Vehicle - to and from court house and work	Times per day	1

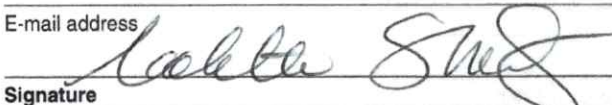
4 Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines?  Yes     No  
 If "Yes", please specify: Often there are short deadlines and short notice to assist clients. The courts often give minimal notice.

5 Does the employee's job require dexterity?  Yes     No  
 If "Yes", please specify: Terri is required to assist clients who are often in crisis. This position requires a high level of mental dexterity. She must be able to provide effective crisis intervention. Terri is also required to meet with clients to provide individual counselling and care plans.

**D - ADDITIONAL INFORMATION**

Terri has a high stress position where she is required to provide support to clients who have been effected by the justice system and have been in crisis. Her job requires her to be focused and provide clients with a lot of attention to ensure proper support is in place. She is a lead in the Gladue program and also oversees the work of other program staff and provides admin support to her manager.

**SIGNATURE OF THE AUTHORIZED PERSON**

Shwetz, Colette	Director of Human Resources
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
cshwetz@nanlegal.on.ca	
E-mail address	
	<u>March 22/24</u>
Signature	Date

# **Direction and Authorization Form**

**DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION**

**FROM** Terri Zoccole  
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.

Terri Zoccole  
Signature of Claimant

March 21, 2024  
Date



## Account Information

Set up your direct deposits and pre-authorized payments easily and conveniently.

Print, sign and submit this form as follows:

Direct Deposit: receive your payroll or other deposits into your account. Complete and submit this form to your employer or the company depositing the payment into your account.

Pre-authorized Payment: automatically pay your bills from your account. Complete and submit this form to your billing company to allow them to take the payment from your account.

Feedback

### Your Information

Name: TERRI-LEA ZOCCOLE  
Address: 421 YORK ST  
THUNDER BAY ON  
P7A 7S1

### Direct Deposit Information

Transit: 00897  
Institution Number: 010  
Account Number: 7563639

### Void Cheque

TERRI-LEA ZOCCOLE  
421 YORK ST  
THUNDER BAY ON  
P7A 7S1

DATE

PAY TO THE ORDER OF \_\_\_\_\_ \$

00897 010 7563639

**CIBC**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**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



GROUP #/SURPOLCF - 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 <b>ZOCCOLE TERRI</b>		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of birth 1970 03 10
Address - No., street, apt. <b>421 YORK ST</b>		City <b>THUNDER BAY</b>	Province <b>ONT</b>
Postal code <b>P7A 7S1</b>		Postal code	
Policy or group or contract no. <b>641028</b>	Division no.	Certificate or identification no.	Social insurance no. <b>481 739 712</b>

Telephone no. (mandatory): **(807) 629-7031**  I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address: **tezoccole@gmail.com**

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

**B - GENERAL INFORMATION**

1. Training:

Level of education:

Work experience: **6 1/2 years at pan legal | 15+ years as a councillor**

Spoken language:  English  French      Written language:  English  French

2. Is disability due to an accident?  Yes  No      If "Yes", date of accident:      Time:      Type of accident:

AMI       Work-related       Motor vehicle       Other

Indicate details (where, how):

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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:

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---

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

**For my son - / my family Doctor Tray Meyers**  
**is also my son's doctor**  
**nurse practitioner**  
**Dilico family Health**

PLEASE COMPLETE THE BACK OF THE FORM.  
 06329E01 (2018-11)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

807  
 606  
 5200

**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			End date of benefits			Benefit amount	Weekly/Monthly	
			YYYY	MM	DD	YYYY	MM	DD		\$	<input type="checkbox"/> W
									\$	<input type="checkbox"/> W	<input type="checkbox"/> M
									\$	<input type="checkbox"/> W	<input type="checkbox"/> M

Comments:

N/A

**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: CIBC Institution no: 010 Transit/branch no: 00897 Account no: 7563639  
 Address - No., street, suite: Arthurst City: Thunder Bay Province: Ontario Postal code:

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 March 21, 2024. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: [Signature] Date: March 21, 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: March 21, 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.

My son who has a <sup>con</sup>genital heart defect got pneumonia and went to the ICU in Thunder Bay, Ontario. He got worse and was transferred to Toronto ICU. He got worse and had to have kidney dialysis. He had been on a breathing tube since March 4, 2024. He ~~is~~ has a PIC line in his left arm. He was to have a tracheostomy, but lucky they extubated him and he tolerated it. He is my youngest son and is doing OK. Two steps forward and one step back. He ~~is~~ has a weaker left side and has CT scan to see if he had a stroke or any brain bleeds.

### Employee Statement

He will need psycho for his left side - still on a feeding tube.

Boocole

March 21, 2024.

I am stressed and feeling very overwhelmed dealing with all that has happened. My head clearly is concentrating on supporting my son. I wake up eat, go hospital and try to sleep. I am tired and exhausted mentally and emotionally. My body is tired. I take everything Day by Day - hour by hour and minute by minute. I need to be strong and I try so hard each day to be. I am tired and wish only to sleep in my own bed - I am so far from home, and all my family - sons and friends.



# **Attending Physician Statement**

**(Please take full package to your physician)**

## 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:

- <u>General</u>	Form no. 12018E01
- Musculo-skeletal	Form no. 12019E01
- <u>Psychiatric/psychological</u>	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](https://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:  
[desjardins.ca/initialattendingphysiciansstatement](#)  
 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) Zocade, Terri-Lea | Policy or group or contract no. 641028 | Certificate or identification no. | Date of birth 1970 03 10

### 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: Mental health stress leave
- 1.2 Secondary: Compassionate care / family care
- 1.3 Subjective symptoms (including severity, frequency, duration): patient currently providing support to critically ill son.
- 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: Son presented to hospital March 02, 2024
  - 2.2 Date patient's condition first prevented them from working: I believe she began taking time off March 02, 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.: N/A

2.7 Names and specialties of other treating physicians: The patient is currently in Southern Ontario spending time at the bedside of her critically ill child.

2.8 Current height: | Current weight: | Weight loss/gain to date:

#### 3. Treatment dates

- 3.1 Date of first visit for current condition: 2024 03 02
- 3.2 Date of latest visit: Son admitted
- 3.3 Frequency of visits:  Weekly  Monthly  Other (specify): Daily
- 3.4 Date of in-patient admission:
- 3.5 Date of discharge: Son still admitted.
- 3.6 Date of out-patient treatment: N/A
- 3.7 Name of hospital: Transferred from Thunder Bay to I believe London.

#### 4. Nature of treatment

- 4.1 Medications (dose, frequency, date prescribed): mental health stress leave / compassionate care leave to be with son
- 4.2 Surgeries (including dates):
- 4.3 Other (including frequency):
- 4.4 Is patient following recommended treatment program?  Yes  No (please elaborate):