

EMPLOYER INFORMATION

The purpose of this form is to enable us to process the claim as quickly as possible and to assist us in evaluating the possibility of providing your employee with rehabilitation assistance, etc.

Please complete these questions as accurately as possible.

Claimant's Name: _____

Group Policy No.: _____

Employer: _____

Exact Job Title: _____

Length of time in this Job: _____

Other Job Positions Held at the Employer and Length of Service: _____

Date last worked: _____

Number of hours _____

Effective date of insurance
applicable to this claim _____

Date insurance terminated _____

Is the condition due to injury or illness arising out of employment? Yes No

If yes, has a claim been submitted to WSIB/WCB? Yes No

Employee's gross monthly earnings: \$ _____

Dates covered by salary continuation, sick leave plan(s) or EI _____

Non-Taxable Benefits:

Show applicable payroll deductions and check frequency

Income Tax _____

EI _____

CPP/QPP _____

Mandatory Pension Plan _____

Weekly Bi-Weekly Monthly Other

Has this job been eliminated? Yes No

If the employee's salary varies or is based on commissions, please include the previous year's T4 slip for Revenue Canada. If this employee receives commissions and/or bonuses, please provide details (i.e. amounts, frequency, etc.)

If this disability commenced within 12 months of the employee's effective date of long term disability insurance, please answer the following questions.

a) Was the employee actively at work on a full-time basis for a continuous period of 90 days ending on or after the date on which the employee became insured for long term disability benefits? Yes No

b) Was the employee absent from work, due to disability, during the 12 months prior to the effective date of the employee's insurance? Yes No

c) Did the employee have LTD coverage with your previous carrier? Yes No

If yes, we require a copy of the LTD policy pages and a copy of your final billing from your previous carrier.

Indicate why employee stopped working:

Illness

Other (explain)

Injury

Layoff

Leave of absence

Is there a possibility that you can provide this employee with modified or light duties, considering the nature of the disability?

Yes No

If yes, please explain:

Describe in detail what the job involves including shift work, week-ends, supervisory responsibilities and whether job is dependent upon others or whether their job depends on this employee.

If you have a job description or PDA of the employee's job, please submit a copy along with the completed form.
List all types of machines, tools, office equipment and other special equipment this employee uses to do his/her job.

What functions are required or considered necessary to operate the equipment in a safe manner?

Describe the work environment with regards to presence of respiratory irritants, noise, humidity, heat, cold, hazards, etc.

- Sedentary Duties:** Exerting up to 10 pounds (4.5 kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary Duties involve sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- Light Duties:** Exerting up to 20 pounds (9.1 kg) of force occasionally and/or up to 10 pounds (4.5 kg) of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Duties. Light Duties usually require walking or standing to a significant degree. However, if the use of the arm and/or leg controls requires exertion of forces greater than that for Sedentary Duties and the worker sits most of the time, the job is rated Light Duties.
- Medium Duties:** Exerting up to 50 pounds (22.7 kg) of force occasionally, and/or up to 25 pounds (11.3 kg) of force frequently, and/or up to 10 pounds (4.5 kg) of force constantly to move objects.
- Heavy Duties:** Exerting up to 100 pounds (45.4 kg) of force occasionally, and/or up to 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects
- Very Heavy Duties:** Exerting in excess of 100 pounds (45.4 kg) of force occasionally, and/or in excess of 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects.

The Department of Labour job classifications focus on physical effort only. This may not be relevant to the duration of some disability. In addition to pounds of force, other important factors contribute to the definition of an individual's job classification. These factors include posture, biomechanics (size, shape, and manageability of the object being moved), height from and to which the object is lifted, and frequency of exertion. Each of these factors (and any other job-specific requirements) should be considered when determining expected length of disability.

Please Mark off (x) in the applicable spaces below, those physical activities REQUIRED in this job.

PHYSICAL ACTIVITIES REQUIRED	TOTAL HOURS PERFORMED DAILY			
	Less than	1-2	3-4	5-6
LIFTING				
Under 10 pounds				
10-20 pounds				
20-50 pounds				
Over 50 pounds				
CARRYING				
Under 10 pounds				
10-20 pounds				
20-50 pounds				
Over 50 pounds				
REACHING				
Above shoulder height				
At shoulder height				
Below shoulder height				

In the normal work day, how long would this employee be in the following positions if he/she was doing his/her regular occupation?

Sitting	hours	Seeing	hours
Standing	hours	Pushing/Pulling	hours
Walking	hours	Gripping	hours
Talking	hours	Pinching	hours
Hearing	hours	Overhead Lifting	hours

Regular hours of work:	Days of work week:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
First Break:	From:	To:						

Please indicate what (if any) modified duties and/or hours are available for this employee.

Please indicate the time period (in months and years) necessary to master activities involved in this job and the general training usually required before such employment can be obtained.

Present Status of employee: On disability leave Terminated On Pension Other:

Are you aware of the claimant being involved in any other type of occupation prior to disability?
i.e. part-time employment elsewhere or home-based business.

If the employee would not be able to return to his/her regular occupation, do you have any alternative job openings?
Could his/her skills be used in any other type of work?

Are there any circumstances which would cause you to question the validity of this claim? Yes No

Any additional information that may be helpful in this evaluation?

Date: _____ Employer Name: _____

Authorized Name of Employer/Plan Administrator (please print): _____ Authorized Signature of Employer/Plan Administrator: _____

Title: _____

Telephone No.: _____ Fax No.: _____

Please forward completed form promptly to:
Group Claims Department
The Equitable Life Insurance Company of Canada
One Westmount Road North, PO Box 1603, Stn. Waterloo
Waterloo, Ontario N2J 4C7