Equitable Life of Canada®

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Short Term Disability Claim Form

I. Employee Section
Please print or type

Last Name | First Name

Address - Number and Street | Apt. No. | City | Prov. | Postal Code

Cause of Disability | Telephone No. (Area Code) | Date of Birth (Day / Month / Year)

Date of disability → (Day / Month / Year) | If you have returned to work, give date or expected return date → (Day / Month / Year)

Is disability the result of an accident? ☐ Yes ☐ No → If "yes", time and date → Time ☐ a.m. ☐ p.m. (Day / Month / Year)

Give full details of the accident (How and where it happened and resulting injuries)

Location of Accident: ☐ Work ☐ Home ☐ Elsewhere

Has or will claim be filed for WSIB/WCB? ☐ Yes ☐ No → If "yes", Claim # → Has claim been approved? ☐ Yes ☐ No

Are you receiving or are you eligible for benefits from any other source such as other insurance, car insurance, pension, E.I.? ☐ Yes ☐ No → If "yes", state details (source, amount, policy number or other identification)

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify that the information given on this form is true, correct and complete.

For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada ("Equitable"), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health, to give to Equitable full particulars of such information, including any prior medical history and benefits.

I transfer and assign to Equitable, and agree to pay and refund to Equitable those disability and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Worker's Compensation, and other insurance policies.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

Date: _____ Signature: _____

II. Employer/Plan Administrator Section → *Form should be completed within 7 days of disability. Do not wait until the employee returns to work.*

Employee Name

Group No. | Employee's Certificate/Social Insurance No. (S.I.N. is required for taxable benefits)

Date of Hire (Day / Month / Year) | Occupation

Effective Date of Insurance (Day / Month / Year) | If terminated/laid off, give date (Day / Month / Year)

Date Last Worked (Day / Month / Year) | Date Returned to Work (Day / Month / Year)

For TPA and self-administered groups: please indicate the amount of Short Term Disability coverage:

$_____

Regular Gross Earnings per week (prior to disability) $ _____

Deduction section must be completed if your plan is Non-taxable (i.e. employee pays 100% of premiums)

Deductions:
- Income Tax $ _____
- C.P.P. $ _____
- E.I. $ _____
- Pension Plan $ _____
- Net Earnings $ _____

Is disability due to occupational accident or sickness? ☐ Yes ☐ No

Has disability been reported to the WSIB/WCB? ☐ Yes ☐ No

Does employee receive any pay or benefits while disabled? ☐ Yes → If "yes", give details/comments in ***Comments*** section below ☐ No

Comments: Include (where applicable) reason claim has been delayed, whether employee is on vacation, any dates the employee has worked since first disabled, or any other information which will assist the company in considering the claim.

Employer Name | Telephone No. (Area Code) | Fax No. (Area Code)

Employer Address - Number and Street | Suite No. | City | Prov. | Postal Code

Signature and Title of Plan Administrator | Date (Day / Month / Year)

421(2009/04/01)

Attending Physician's Statement

Instructions: 1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. ***Any charge*** *for completing this form is the patient's responsibility.*

Part 1: Patient Information

Policy No.

Last Name	First Name	Date of Birth (Day / Month / Year)

I hereby authorize the release to my insurer of any information in respect of this claim. | Patient's Signature | Date (Day / Month / Year)

Part 2: Attending Physician's Statement

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge:
   a) indicate when symptoms first appeared or accident happened. (Day / Month / Year)
   b) has patient had same or similar condition ☐ No ☐ Yes → If "yes", please state when and describe. (Day / Month / Year)

3. Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

4. If patient is/was pregnant indicate:
   a) expected date of delivery _____ b) actual date of delivery _____
   c) type of delivery (if applicable): vaginal _____ caesarean _____

5. Nature of treatment *(e.g. date and type of surgery, names and dosages of medications prescribed).*

6. Date of hospital admission (Day / Month / Year) | Date of hospital discharge (Day / Month / Year) | Was this day surgery procedure? ☐ No ☐ Yes

7. a) If patient was referred to you, give name of referring physician.
   b) If you have referred patient to a specialist, give name(s) of physicians.
   c) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present conditions
   From: (Day / Month / Year) To: (Day / Month / Year)

8. a) Date of first visit during present period of absence from work (Day / Month / Year) b) Date of latest attendance (Day / Month / Year)
   c) Were you actively supervising this patient's care during the full period?
   ☐ No, comment in remarks ☐ Yes, state frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify)

9. Please advise how the current medical restrictions/limitations affect the patient's ability to work.

10. Extent of Disability

	For Regular Occupation	*Any Other Occupation*
a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
b) If "No", when was patient able to resume work?	Day / Month / Year	Day / Month / Year
c) If "Yes", when should patient be able to resume work?	Day / Month / Year	Day / Month / Year
d) If indefinite, give approx. date patient should be able to return.	Day / Month / Year	Day / Month / Year
e) Could patient work part time or modified duties if available?	Day / Month / Year	Day / Month / Year

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (please print)	Specialty	Telephone No. (Area Code) / Fax No. (Area Code)

Address - Number and Street	Suite No.	City	Prov.	Postal Code

Signature | Date (Day / Month / Year)

421(2009/04/01)