# REQUEST FOR DISABILITY BENEFITS

## GROUP INSURANCE

**IMPORTANT :** AS SOON AS AN EMPLOYEE IS ABSENT FROM WORK AND IS ELIGIBLE FOR DISABILITY BENEFITS, OR QUALIFIES FOR WAIVER OF PREMIUM, PLEASE TRANSMIT THIS FORM TO THE INSURER IMMEDIATELY. ANY INITIAL REQUEST SHOULD INCLUDE AN EMPLOYER'S DECLARATION, EMPLOYEE'S DECLARATION AND ATTENDING PHYSICIAN'S STATEMENT DULY COMPLETED AND SIGNED.

**SHORT TERM DISABILITY** ☐
**LONG TERM DISABILITY** ☐
**WAIVER OF PREMIUM** ☐

## EMPLOYER'S DECLARATION

| GROUP | DIVISION | CLASS | **CERTIFICATE** |
|---|---|---|---|
| | | | |

| NAME OF EMPLOYEE | SURNAME | SOCIAL INSURANCE NUMBER |
|---|---|---|
| | | |

OCCUPATION
PLEASE INDICATE THE PRINCIPAL FUNCTIONS AND RESPONSABILITIES, AND ATTACH A COPY OF THE JOB DESCRIPTION, IF POSSIBLE.

_____

_____

| DATE EMPLOYED (D M Y) | EMPLOYEE'S WEEKLY GROSS SALARY | SINCE WHAT DATE (D M Y) |
|---|---|---|
| | _____ $ REGULAR WEEK HOURS _____ | |

LAST DAY WORKED

| FULL TIME DATE (D M Y) | HOUR | PART TIME DATE (D M Y) | HOUR |
|---|---|---|---|
| | _____ A.M. ☐ P.M. ☐ | | _____ A.M. ☐ P.M. ☐ |

DEDUCTIONS : ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER : _____

| | EXEMPTION CODE | INCOME TAX WITHHELD | CONTRIBUTIONS QPP / CPP | UNEMPLOYMENT INSURANCE |
|---|---|---|---|---|
| FEDERAL | | | | |
| PROVINCIAL | | | | |

HAS THE EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐ IF YES, INDICATE DATE (D M Y) _____

HAS THE EMPLOYEE RETURNED TO HIS REGULAR OCCUPATION FOR AT LEAST 20 HOURS A WEEK? YES ☐ NO ☐

IF NO, EXPLAIN : _____

IS THE DISABILITY DUE TO A WORK RELATED INJURY OR ILLNESS? YES ☐ NO ☐

HAS A DISABILITY CLAIM BEEN FILED WITH WORKERS' COMPENSATION BOARD? YES ☐ NO ☐

IF YES, HAS THE CLAIM BEEN ACCEPTED? YES ☐ NO ☐

IS THE CERTIFICATE TERMINATED? YES ☐ NO ☐ IF YES, SINCE WHAT DATE? (D M Y) _____

IN YOUR OPINION IS THIS REQUEST JUSTIFIED? YES ☐ NO ☐

IF NOT, EXPLAIN _____

| DATE | NAME OF EMPLOYER |
|---|---|
| | |

| BY | TITLE |
|---|---|
| | |