

The Employer's and Employee's statements should be completed and sent to Canada Life at least 8 weeks before the waiting period ends when applying for long term disability, or within 10 days of the disability date when applying for short term disability. Canada Life's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee.

**Ensure all sections are completed to prevent any delay in assessing this claim**

**Company name:** \_\_\_\_\_  
**Plan number:** \_\_\_\_\_ **Canada Life ID number:** \_\_\_\_\_ **Division:** \_\_\_\_\_ **Class:** \_\_\_\_\_

## Employee's information

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_  
**Date of Birth (mm/dd/yyyy):** \_\_\_\_\_ **Social Insurance Number:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
**City / Town:** \_\_\_\_\_ **Province / Territory:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

## Employment information

**Job title:** \_\_\_\_\_ **Date of hire (mm/dd/yyyy):** \_\_\_\_\_  
**Gross earnings prior to disability:** \_\_\_\_\_ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually  
**Employee is:**  
a) ☐ Full time ☐ Part-time  
b) ☐ Permanent ☐ Temporary ☐ Seasonal ☐ Contract  
c) ☐ Hourly ☐ Salaried ☐ Commissioned ☐ Salaried + Commissioned  
☐ Hourly + Commissioned  
☐ Other – describe: \_\_\_\_\_

**Regular number of scheduled hours:** \_\_\_\_\_ ☐ Weekly ☐ Bi-weekly ☐ Monthly

**Do the schedule hours vary (excluding overtime)?** ☐ Yes ☐ No

**Is the employee still employed?** ☐ Yes ☐ No **Date employment ended (mm/dd/yyyy):** \_\_\_\_\_

## Coverage information

**Date the employee signed their enrollment form for disability coverage (mm/dd/yyyy):** \_\_\_\_\_  
**Date the employee was added to the plan for disability coverage (mm/dd/yyyy):** \_\_\_\_\_  
**What is the basic disability coverage amount for the employee:** \_\_\_\_\_ per week \_\_\_\_\_ per month.  
**Does the employee have any excess insurance?** ☐ No ☐ Yes **Amount:** \_\_\_\_\_  
**Is the employee covered for basic life insurance?** ☐ No ☐ Yes **Amount:** \_\_\_\_\_  
**Is the employee covered for optional life insurance?** ☐ No ☐ Yes **Amount:** \_\_\_\_\_

## Employee's tax information

**TD-1 personal tax credits (federal):** \_\_\_\_\_ (provincial): \_\_\_\_\_ **OR Quebec TP-1015.3 source deductions:** \_\_\_\_\_  
**Is the employee exempt from tax under the Indian Act (CRA form TD1-1N)?** ☐ No ☐ Yes **What percentage?** \_\_\_\_\_ %

**Complete this section if your plan is ASO and you have authorized Canada Life to deduct CPP/QPP and EI/QPIP from the employee on your behalf. Enter the year-to-date amounts from your payroll system based on wages you've paid:**

**Employee's province of employment:** \_\_\_\_\_  
**Year-to-date CPP/QPP(1) Contributions:** \_\_\_\_\_ **Year-to-date CPP/QPP(2) Contributions:** \_\_\_\_\_  
**Year-to-date EI Premiums:** \_\_\_\_\_ **QPIP Premiums:** \_\_\_\_\_  
**Year-to-date Pensionable Earnings:** \_\_\_\_\_ **Insurable Earnings:** \_\_\_\_\_

## Absence information

Employee's last day actively at work (mm/dd/yyyy): \_\_\_\_\_ Percentage of last day worked: \_\_\_\_\_ %

Employee's first day absent from work (mm/dd/yyyy): \_\_\_\_\_

Have you paid the employee beyond their last day worked? ☐ No ☐ Yes

Date paid to (mm/dd/yyyy): \_\_\_\_\_ OR ☐ Ongoing

Type of pay: ☐ Sick pay/Salary continuance ☐ Vacation ☐ Other (please specify): \_\_\_\_\_

What is the reason for the employee's absence (select all that apply):

☐ Medical

☐ Strike

☐ Temporary lay-off Start date: \_\_\_\_\_ (mm/dd/yyyy) Recall date (if known): \_\_\_\_\_

☐ Maternity/Parental leave Start date: \_\_\_\_\_ (mm/dd/yyyy) Planned end date: \_\_\_\_\_

☐ Leave of absence Start date: \_\_\_\_\_ (mm/dd/yyyy) Planned end date: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Is this absence due to a work related incident? ☐ No ☐ Yes Has a Worker's Compensation claim been filed? ☐ No ☐ Yes

Worker's Compensation Claim number (If known): \_\_\_\_\_

Has the employee returned to work? ☐ No ☐ Yes If yes, date returned (mm/dd/yyyy): \_\_\_\_\_

The employee has returned to (select all that apply) ☐ Regular hours and duties ☐ Modified duties ☐ Modified hours

Details: \_\_\_\_\_

If no, date expected to return (mm/dd/yyyy): \_\_\_\_\_ OR ☐ Unknown

Were there any workplace issues leading up to the employee's absence? ☐ No ☐ Yes ☐ Unknown

Do you anticipate any difficulties with the employee's return to work? ☐ No ☐ Yes ☐ Unknown

Do you have any concerns with this claim for disability benefits? ☐ No ☐ Yes ☐ Unknown

Have you remained in contact with this employee? ☐ No ☐ Yes ☐ Unknown

Have you discussed accommodation options with this employee? ☐ No ☐ Yes ☐ Unknown

If yes or unknown to any of these questions, please provide details. A Canada Life representative may contact you to discuss further.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Declaration

☐ I declare the information I have entered is accurate Date : \_\_\_\_\_

Name of contact person: \_\_\_\_\_ Job title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Confidential fax: \_\_\_\_\_

Email: \_\_\_\_\_

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

**If submitting this form by fax or email, the Authorized Signature field must be signed.**

**If submitting this form on-line, on-line certification will be applied.**

**PART 1 – To be completed by the Employee's supervisor**

How would you classify the **physical** requirements of the employee's regular job duties?

<input type="checkbox"/>	Sedentary	Mostly sitting, limited bending, reaching or climbing. Involves handling loads or exerting force up to 10 lbs/4.5 kgs occasionally. For example: <ul style="list-style-type: none"> <li>Examining and analyzing financial information</li> <li>Administering and marking written tests</li> </ul>
<input type="checkbox"/>	Light	Sitting and standing/walking. Occasional bending/stooping, reaching or climbing. Involves handling loads or exerting force between 10 lbs/4.5 kgs and 20 lbs/9.1 kgs occasionally. For example: <ul style="list-style-type: none"> <li>Preparing and cooking meals</li> <li>Filing materials in drawers and storage boxes</li> </ul>
<input type="checkbox"/>	Medium	Standing/walking, occasional sitting. Frequent bending/stooping, reaching, climbing. Involves handling loads or exerting force between 20 lbs/9.1 kgs and 50 lbs/22.7 kgs occasionally. For example: <ul style="list-style-type: none"> <li>Measuring, cutting and applying wallpaper</li> <li>Adjusting, repairing or replacing mechanical or electrical components using hand tools</li> </ul>
<input type="checkbox"/>	Heavy	Mostly standing/walking. Frequent bending/stooping, reaching, climbing. Involves handling loads or exerting force up to 100 lbs/45.4 kgs occasionally. For example: <ul style="list-style-type: none"> <li>Shoveling cement into mixers, the maintenance and repair of roads</li> <li>Measuring, cutting and installing drywall</li> </ul>

How would you classify the **cognitive** requirements of the employee's job duties?

<input type="checkbox"/>	Low	Repetitive work or work requiring minimal concentration, organization, decision making and/or multi-tasking with basic communication or social interaction. For example: <ul style="list-style-type: none"> <li>Stocking shelves</li> <li>Ticket taking, greeting customers</li> <li>Light labor or cleaning</li> </ul>
<input type="checkbox"/>	Moderate	Routine work involving some concentration, organization, decision making and/or multi-tasking, communication or social interaction. For example: <ul style="list-style-type: none"> <li>Quality reviews using a checklist</li> <li>Handling customer purchases with a variety of payment methods</li> <li>Answering phones and directing calls</li> </ul>
<input type="checkbox"/>	Moderately high	Detailed work involving a significant level of concentration, organization, decision making, multi-tasking, communication or social interaction. <ul style="list-style-type: none"> <li>Examining and analyzing financial information</li> <li>Operating heavy machinery</li> <li>Driving to customer locations daily for sales/service appointments</li> </ul>
<input type="checkbox"/>	High	Specialized, detailed work or safety critical positions involving an extensive level of concentration, organization, decision making, multi-tasking and communication. For example: <ul style="list-style-type: none"> <li>Examining patients and administering testing/treatment</li> <li>Public transportation, public safety</li> </ul>

How long has the employee worked in this position? \_\_\_\_\_ Years \_\_\_\_\_ Months

Were any changes made to the employee’s job as a result of their medical condition? ☐ No ☐ Yes

Please describe the changes and when the changes occurred.

Outline the transitional work opportunities (such as modified duties, temporary accommodations, gradual increase of hours) that may exist for the employee:

PART 2 – To be completed by the Employee’s supervisor

Not required if:

- the employee has returned to work or if the absence will be less than 4 weeks.
- you have a prepared job description outlining the physical and/or cognitive demands (please attach).

Select the option that describes how long/how often the employee performs each activity during their normal workday.

Cognitive Activities	Constantly (85-100%)	Frequently (65-84%)	Regularly (34-64%)	Occasionally (33% or less)	Not at all
Attention to Detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi-tasking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading/writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Endurance	Up to 4 hours continuously	2-4 hours continuously	1-2 hours continuously	up to 1 hour continuously	up to 20 mins continuously	Not at all
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Part 2 – continued

Activity		Constantly (85-100%)	Frequently (65-84%)	Regularly (34-64%)	Occasionally (33% or less)	Unable/ Not at all	Expected duration of any restrictions
Bend/Stoop		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squat/Kneel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb stairs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate foot controls	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Push/Pull	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach							
Below shoulder	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Above shoulder	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hand dexterity							
Gross manipulation (grip/ grasp)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fine manipulation (type/write/grip)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift/Carry up to 10 lbs/4.5 kgs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift/Carry up to 20 lbs/9.1 kgs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift/Carry up to 50 lbs/22.7 kgs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide any additional information that you believe should be considered when assessing the employee's claim.

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## Declaration

☐ I declare the information I have entered is accurate Date : \_\_\_\_\_

Name of contact person: \_\_\_\_\_ Job title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Confidential fax: \_\_\_\_\_

Email: \_\_\_\_\_

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

***If submitting this form by fax or email, the Authorized Signature field must be signed.  
If submitting this form on-line, on-line certification will be applied.***