

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?** _____ %

This section must be completed if your plan is Administrative Services Only (ASO) and you have authorized Canada Life to deduct CPP/QPP and EI/QPIP from the employee on your behalf:

Employee's province of employment: _____

Enter the year-to-date amounts deducted from your payroll system based on wages you've paid:

Year-to-date CPP/QPP Contributions: _____ **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"> Examining and analyzing financial information Administering and marking written tests
<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"> Preparing and cooking meals Filing materials in drawers and storage boxes
<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"> Measuring, cutting and applying wallpaper Adjusting, repairing or replacing mechanical or electrical components using hand tools
<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"> Shoveling cement into mixers, the maintenance and repair of roads Measuring, cutting and installing drywall

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"> Stocking shelves Ticket taking, greeting customers Light labor or cleaning
<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"> Quality reviews using a checklist Handling customer purchases with a variety of payment methods Answering phones and directing calls
<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"> Examining and analyzing financial information Operating heavy machinery Driving to customer locations daily for sales/service appointments
<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"> Examining patients and administering testing/treatment Public transportation, public safety

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.

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.