Case postale 3800
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All provinces or territories – except Quebec: 1-800-278-0669
Quebec: 1-888-558-5525

INDIVIDUAL INSURANCE

Disability claim

Employer or self-employed individual's statement

☐ Employer ☐ Self-employed individual

We are unable to assess this claim unless all questions are answered completely.

Contract number

A. IDENTIFICATION OF PERSON INSURED

Disabled person's last name	First name	Date of birth
		YYYY-MM-DD

B. IDENTIFICATION OF EMPLOYER (IF APPLICABLE)

Name of employer

Name of the contact person

Address of employer – No., street, apt.

City

Province

Postal code

Telephone Nos. (Area code + number)

Ext.:

Fax No. (Area code + number)

C. GENERAL INFORMATION

1. Current weekly salary
2. Salary effective date YYYY-MM-DD
3. ☐ Full-time ☐ Part-time
4. Hours worked/week
5. Date of employment YYYY-MM-DD
6. Occupation
7. Last complete day worked YYYY-MM-DD
8. Was this an accident? ☐ Yes ☐ No If yes, date of accident YYYY-MM-DD
9. Specify the number of hours worked over each of the 4 weeks preceding disability:

	From	To	Number of hours	Explain any periods of less than 20 hours:
Week 1	YYYY-MM-DD	YYYY-MM-DD		
Week 2	YYYY-MM-DD	YYYY-MM-DD		
Week 3	YYYY-MM-DD	YYYY-MM-DD		
Week 4	YYYY-MM-DD	YYYY-MM-DD		

10. Did or will the disabled person receive any income during the disability period? ☐ Yes ☐ No If yes, specify:
    ☐ Holiday pay ☐ Maternity ☐ Disability ☐ Salary ☐ Lump sum ☐ Other:
    Amount: Benefit payment period: From: YYYY-MM-DD to: YYYY-MM-DD
    Name of insurance companies: Policy No.: Certificate No.:
11. If the disabled person is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (formerly the CSST)? ☐ Yes ☐ No
12. Has a claim been filed with a government agency? ☐ Yes ☐ No If yes, specify:
    ☐ CNESST any other similar organization ☐ Retraite Québec (QPP)/CPP ☐ SAAQ
    ☐ Employment insurance (unemployment or sickness benefits) Other:
    Date filed: YYYY-MM-DD Decision rendered: Amount:
13. Has the disabled person returned to work? ☐ Yes ☐ No If yes, on what date? YYYY-MM-DD
14. Is this a temporary assignment? ☐ Yes ☐ No If yes, since what date? YYYY-MM-DD

Attach documents from the physician or CNESST.

15. Was work attendance affected by illness or accident during the last 2 years preceding disability? ☐ Yes ☐ No If yes, dates absent:

Disabled person's last name	First name	Date of birth
		YYYY-MM-DD

C. GENERAL INFORMATION (CONT.)

16. Is the disabled person still in your employ? ☐ Yes ☐ No If no, termination date: YYYY-MM-DD
Reason:

17. Over the past year:

a) Has the level or nature of the disabled person's responsibilities changed? ☐ Yes ☐ No If yes, please explain:

b) Were the tasks modified? ☐ Yes ☐ No If yes, please explain:

c) In your opinion, is the disabled person's current state of health related to work? ☐ Yes ☐ No If yes, please explain:

D. PHYSICAL WORK ENVIRONMENT

⚠ Please attach a brief job description if available.

1. What are the main duties of the disabled person's job and how much time is allocated to each one weekly?

Duties	%	Duties	%
Duties	%	Duties	%

⚠ For questions 2 and 3, frequency is defined as follows:
Occasionally: 0-15% of the time **F**requently: 16-50% of the time **A**lways: 51% + of the time

2. Work environment - Does the disabled person's job require work in any of the following conditions?

Frequency:	O	F	A	Frequency:	O	F	A	Frequency:	O	F	A
☐ Outside	☐	☐	☐	☐ In a damp or humid environment	☐	☐	☐	☐ Above or below ground level	☐	☐	☐
☐ In extremes of cold or heat	☐	☐	☐	☐ Toxic fumes	☐	☐	☐	☐ Handling chemicals	☐	☐	☐

Does the job involve other hazards? ☐ Yes ☐ No If yes, please list:

3. Check the items below that relate to the disabled person's job, and complete the information requested.

Frequency:	O	F	A	Frequency	O	F	A	Frequency:	O	F	A
☐ Standing	☐	☐	☐	☐ Bending over	☐	☐	☐	☐ Extending/reaching above head	☐	☐	☐
☐ Walking	☐	☐	☐	☐ Kneeling	☐	☐	☐	☐ Climbing	☐	☐	☐
☐ Sitting	☐	☐	☐	☐ Crouching	☐	☐	☐	☐ Stairs (No. of steps ______)	☐	☐	☐
☐ Keeping one's balance	☐	☐	☐	☐ Crawling	☐	☐	☐	☐ Ladders (Height ______)	☐	☐	☐

Describe activity and specify frequency and weight:

	Frequency: O	F	A	Weight
☐ Pushing ______	☐	☐	☐	
☐ Pulling ______	☐	☐	☐	
☐ Lifting/carrying ______	☐	☐	☐	

Please list any office equipment, motor vehicle, tools or other equipment that is used in the disabled person's job.

Type of equipment	Times per day	Type of equipment	Times per day

4. Does the disabled person work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines?
☐ Yes ☐ No If yes, please specify:

5. Does the disabled person's job require dexterity? ☐ Yes ☐ No If yes, please specify:

6. Are there any other potential work-related factors which may influence this disabled person's return to work? ☐ Yes ☐ No If yes, please specify:

E. SIGNATURE OF EMPLOYER

Signature of authorized person ______________________ **Date** ______________