Print

iA Financial Group

DISABILITY CLAIM FORM
POLICYHOLDER'S STATEMENT

GROUP INSURANCE

According to your region, please submit the completed form to:

Quebec
PO Box 790, Station B
Montréal, Quebec H3B 3K6
Fax: 1-877-799-6691
disabilitylife@ia.ca

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7
Fax: 1-877-781-1583
disabilityclaims@ia.ca

Type of claim: Short-Term Disability ☐ Long-Term Disability ☒ Waiver of Premium ☐

POLICYHOLDER'S STATEMENT
TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.

1. COVERAGE INFORMATION

Plan Member's Last Name _____ First Name _____

Address _____

_____ Postal Code _____

Home phone # _____ Cell phone # _____

Date of Birth Y M D

Policy # _____ Certificate # _____ Class # _____ Division # _____ (If applicable)

Plan Member's Effective Date of Insurance with Industrial Alliance Y M D

Original Effective Date of Insurance Y M D Date of Hire Y M D

2. WORK SCHEDULE AND EARNINGS INFORMATION

Number of hours worked in a normal week: _____

If an irregular schedule, indicate the number of hours worked for each day:

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____

Gross salary prior to date of disability: $ _____ Paid Monthly ☐ Biweekly ☐ Weekly ☐

Tax credits: Federal (TD1) _____ Provincial (TPD1) _____

Other, please specify _____

During the period of disability, has or will the Plan Member receive:

Statutory holiday pay ☐ Vacation pay ☐ Pay for sick days ☐ Other ☐ _____

Amount $ _____ Period from _____ to _____

Are you able to accommodate: A gradual return to work ☐ Modified duties ☐

_____

3. EMPLOYMENT INFORMATION

Last Day Worked Y M D Date Returned to Work (if applicable) Y M D

Accident at Work Yes ☐ No ☐

Was an accident report filed with WSIB, CSST, Worksafe BC etc? Yes ☐ No ☐ Date filed Y M D

On the date the disability commenced was the employee: On vacation ☐ Laid off ☐ On paid leave ☐ On unpaid leave ☐

On disciplinary suspension with pay ☐ On disciplinary suspension without pay ☐ Other ☐ _____

If returned to work please specify: Full time ☐ Part time ☐ Regular Duties ☐ Modified duties ☐

On the date the Plan Member last worked, what was the member's:

Occupation _____ Please attach a job description if available _____

How long has the member worked in this position? Number of years _____ Number of months _____

If the Plan Member changed jobs or assignments during the 12 months immediately before the last day worked, describe the previous position and provide the reason(s) for the change in job.

_____

_____

_____

_____

Please provide any other comments relevant to this claim: _____

_____

_____

4. WORK DEMANDS INFORMATION

Please complete or attach a Physical Demands Analysis (PDA)

During the Plan Member's normal routine, what percentage of time is he or she required to lift or carry:

	Never	1-25%	26-50%	51-75%	76-100%
More than 10lbs/4.5 kg	☐	☐	☐	☐	☐
More than 20lbs/9.1 kg	☐	☐	☐	☐	☐
More than 50lbs/22.7kg	☐	☐	☐	☐	☐

During the Plan Member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Reaching above shoulder height	☐	☐	☐	☐	☐
Reaching at shoulder height	☐	☐	☐	☐	☐
Reaching below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

How long is the Plan Member required to remain continuously engaged in the following activities without break:

	0-30 minutes	31-60 minutes	61-90 minutes	more than 90 minutes
Continuous Sitting	☐	☐	☐	☐
Continuous Standing	☐	☐	☐	☐

Mental Demands

During the Plan Member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Supervision of others	☐	☐	☐	☐	☐
Tasks with time management pressures	☐	☐	☐	☐	☐
Tasks requiring significant attention to detail	☐	☐	☐	☐	☐

5. POLICYHOLDER INFORMATION

Policyholder's Name _____

Address _____ Postal Code _____

Telephone# _____ Extension _____

E-mail _____

I certify the accuracy of the information above.

Authorized person's name _____

_____ Date Y M D

Signature

If Policyholder unable to provide information regarding Plan Member's work performance or job duties, please provide appropriate contact.

Name _____

Telephone # _____ Extension _____

E-mail _____

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