

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

All provinces except Quebec
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-781-1583

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6
Fax: 1-877-799-6691

TO EXPEDITE PROCESSING AND AVOID FILE REVIEW DELAYS, PLEASE ANSWER ALL QUESTIONS.

1. BASIC INFORMATION

Type of claim: Short-term disability Long-term disability Waiver of premiums

Policy no. _____ Certificate no. _____ Class no. _____ Division no. (if applicable) _____

Department (if applicable) _____

Plan member's first name _____ Last name _____

Date of birth

Y	Y	Y	Y	M	M	D	D

 Work phone no. _____ Ext. _____

Cell phone no. _____ Home phone no. _____

Best time to contact the plan member: AM PM Language: English French

Address _____ Postal code

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Plan member's effective date of insurance with iA Financial Group

Y	Y	Y	Y	M	M	D	D

Hire date

Y	Y	Y	Y	M	M	D	D

 Plan member's original effective date of insurance – following hire date

Y	Y	Y	Y	M	M	D	D

Benefits	Current insurance amount
Basic life insurance – Plan member	
Basic life insurance – Dependents	
Optional life insurance	
1. Plan member	
2. Spouse	
3. Children	
Basic accidental death and dismemberment (AD&D) – Plan member	
Optional accidental death and dismemberment (AD&D)	
1. Plan member	
2. Spouse	
3. Children	
Long-term disability – Plan member	

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: \$ _____ Effective date

Y	Y	Y	Y	M	M	D	D

Paid: Annually Monthly Semi-monthly Biweekly Weekly Hourly

Tax credits: Federal (TD1) _____ Provincial (TP-1015.3) _____

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? No Yes

Modified duties? No Yes

3. EMPLOYMENT INFORMATION

Last day worked

Y	Y	Y	Y	M	M	D	D

 Date of return to work (if applicable)

Y	Y	Y	Y	M	M	D	D

Primary reason for the absence: Motor vehicle accident Work accident Off-duty accident Occupational illness Other illness

If it was a work accident, was a report filed with a workers' compensation board (e.g., WorkSafeBC, WSIB, CNESST, etc.)?

No Yes Date

Y	Y	Y	Y	M	M	D	D

On the date the disability commenced, was the plan member: 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 their occupation? _____
Please attach a job description if available.

How long has the plan 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 are they required to lift or carry the following?

	Never	1-25%	26-50%	51-75%	76-100%
More than 10lbs/4.5kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 20lbs/9.1kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 50lbs/22.7kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tasks with time management pressures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tasks requiring significant attention to detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. POLICYHOLDER/PLAN ADMINISTRATOR INFORMATION

Authorized person

First name _____ Last name _____
 Phone no. _____ Ext. _____ Email address _____

I certify the accuracy of the information above.

Signature _____ Date

Y	Y	Y	Y	M	M	D	D
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If you are unable to provide information regarding the plan member's work performance or job duties, please provide an appropriate contact.

Person in charge of disability files for the group insurance plan

First name _____ Last name _____
 Phone no. _____ Ext. _____ Email address _____