



Disability Application for Group Life Waiver of Premium Benefit Employer Statement

The Employer's and Employee's Statements should be completed and sent to Canada Life at least 8 weeks before the waiting period ends. Canada'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: _____

EMPLOYEE IDENTIFICATION					
First Name	Middle Initial	Last Name	Canada Life ID Number	Division	Class
Date of Birth (MM/DD/YY)		If plan is taxable provide Social Insurance Number	Home Phone Number	Cell Phone	Work Phone
Home Address		City/Town	Province	Postal Code	

EMPLOYMENT INFORMATION	
Job title: _____	Effective date of hire: _____ (MM/DD/YY)
Employee's gross earnings prior to disability: _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
Complete every question in this section including a), b), and c).	
Employee is:	a) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
	b) <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Contract
	c) <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Commissioned <input type="checkbox"/> Salaried and Commissioned <input type="checkbox"/> Hourly and Commissioned
	<input type="checkbox"/> Other Description: _____
Regular number of scheduled hours: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly
Do the scheduled hours vary (excluding overtime)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date employment ended: _____ (MM/DD/YY)

COVERAGE INFORMATION - When the employee enrolled and was added with coverage under this plan.	
Date the employee signed their enrollment form requesting to be added to the plan with group coverage: _____	(MM/DD/YY)
The employee's coverage effective date. The date the employee was added to the plan with group coverage: _____	(MM/DD/YY)
Basic life insurance amount for the employee: _____	
Does the employee have any optional life insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	Amount of optional life insurance: _____
Are premiums still being paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date premiums stopped being paid: _____

ABSENCE INFORMATION

Employee's last day of work: _____ (MM/DD/YY) Percentage of day worked on last day _____ %
Employee's first day absent from work: _____ (MM/DD/YY)

What is the reason for the employee's absence from work? *Select all that apply:*

- Medical
- Strike
- Temporary Lay-off Start date _____ (MM/DD/YY) Recall date (if known) _____ (MM/DD/YY)
- Maternity Leave of Absence Start date _____ (MM/DD/YY) Planned end date _____ (MM/DD/YY)
- Leave of Absence Start date _____ (MM/DD/YY) Planned end date _____ (MM/DD/YY)
- Other _____

Is the absence due to a work related incident?
 No Yes Has a worker's compensation claim been filed? No Yes

Has the employee returned to work?
 No When do you expect the employee to return to work? _____ (MM/DD/YY) **OR** Unknown
 Yes Date returned to work: _____ (MM/DD/YY)
The employee first returned to (*select all that apply*): Regular duties and hours Modified duties Modified hours

Were there any workplace issues leading up to the employee's absence? Yes No Unknown
Do you anticipate any difficulties with the employee's return to work? Yes No Unknown
Do you have any concerns with this employee's claim for disability benefits? Yes No Unknown
If yes or unknown to any of these questions, please explain. *A Canada Life claim representative may contact you to discuss further.*

DECLARATION

I declare the information I've entered is accurate. Today's Date (MM/DD/YY): _____
Name of Contact Person Job Title

Phone Number Email Address Confidential Fax Number

Address City/Town Province Postal Code

Authorized Signature: _____
If submitting form by fax or email, the Authorized Signature field must be signed.
If submitting form online, online certification will be applied.

EMPLOYEE IDENTIFICATION				
First Name	Middle Initial	Last Name	Plan Number	Canada Life ID Number
_____	_____	_____	_____	_____

JOB INFORMATION - part 1

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

<input type="checkbox"/>	Limited	Work activities involve handling loads up to 5 kg. For example: <ul style="list-style-type: none"> Examining and analyzing financial information. Administering and marking written tests.
<input type="checkbox"/>	Light	Work activities involve handling loads up to 5 kg, but less than 10 kg. For example: <ul style="list-style-type: none"> Repairing soles, heel and other parts of footwear. Filing materials in drawers, cabinets and storage boxes. Preparing and cooking meals.
<input type="checkbox"/>	Medium	Work activities involve handling loads between 10 kg, but less than 20 kg. For example: <ul style="list-style-type: none"> Measuring, cutting and applying wallpaper to walls. Adjusting, repairing or replacing mechanical or electrical components using hand tools and equipment.
<input type="checkbox"/>	Heavy	Work activities involve handling loads more than 20 kg. For example: <ul style="list-style-type: none"> Shoveling cement into cement mixers and assisting in the maintenance and repair of roads. Measuring, cutting and fitting drywall sheets for installation on walls and ceilings. Operating power saws to thin and space trees in reforestation areas.

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

Did you make any changes to the employee's job duties prior to their absence as a result of their medical condition? Yes No

If yes, please explain:

JOB INFORMATION - part 2

Physical and Cognitive Demands

If you have documentation that outlines the physical and/or cognitive job demands you do not need to complete the section(s) below.

I will send a separate document outlining the: Physical job demands Cognitive job demands

Lifting/Carrying - Select the option that describes how often they are lifting/carrying during their normal work day

Weight	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
up to 100 lbs / 45 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 50 lbs / 22.75 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 20 lbs / 9.1 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 10 lbs / 4.5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mobility - Select the option that describes how often they are performing each activity during their normal work day

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Reaching	<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"/>
Kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Endurance - Select the amount of time they are required to remain in an activity before changing to a new activity. In the last column indicate the total hours they are required to be in that activity during the course of their normal work day.

Activity	0-30 Minutes	31-60 Minutes	61-90 Minutes	> 90 Minutes	Total time per day
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours

Cognitive Job Demands - Select the option that describes how often they are performing each activity during their normal work day

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Attention to detail	<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"/>
Analysis	<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"/>
Reading/Writing	<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"/>
Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL INFORMATION

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

DECLARATION

I declare the information I've entered is accurate.

Today's Date (MM/DD/YY): _____

Name of Contact Person _____

Job Title _____

Phone Number _____

Email Address _____

Confidential Fax Number _____

Authorized Signature: _____

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

If submitting form online, online certification will be applied.