Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first. Keep original forms for your records.

By mail:
PO Box 1024 STN A
Toronto On M5W 1G5
Send original forms and keep copies for your records.

By fax:
1-855-678-8124 (toll free)
604-678-8124
Keep original forms for your records.

Desjardins Insurance
Life • Health • Retirement

PPWC
Public and Private Workers of Canada
PPWC - Employer Trusteed Health & Welfare Plan
Participating Employers of the Plan

GROUP INSURANCE - DISABILITY CLAIMS

EMPLOYER'S STATEMENT WEEKLY INDEMNITY

Policy Number 647049

Please complete this form in full to avoid delays in processing of claim and submit to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, online to desjardinslifeinsurance.com/send, by mail to **Desjardins Insurance, Disability Claims, PO Box 1024 STN A, Toronto, ON, M5W 1G5** or by **fax: 604-678-8124**. If this form is faxed, please mail originals. Any questions should be directed to Desjardins Insurance at: 604-718-4422 or 1-877-718-4422.

SECTION 1 General information

Employee's last name and first name	Employee's date of birth YYYY MM DD	Employee's social insurance no.

Certificate, Identification or Payroll number	Division number	Class number
		001

Employee's occupation/Job title	Date of employment YYYY MM DD	Name of mill

Employee's address - No., street, apt.	City	Province	Postal code

Telephone no.: ( ) -	E-mail address:

What was the last day the employee worked? YYYY MM DD	What was the last day for which the employee was paid? YYYY MM DD	What day did the employee return to work (if applicable)? YYYY MM DD

SECTION 2 Earnings information

Employee's card rate on last day worked	Are you aware whether the employee is eligible for benefits from any other source? (e.g. WCB/ICBC)

How many hours per week would the employee be regularly scheduled to work if not disabled?

SECTION 3 Rehabilitation

If the employee wishes to work on a part time or modified basis, is alternate work available? ☐ **Yes** ☐ **No**

SECTION 4 Signature and declaration

Name (Please print)		Title

Telephone	Fax	Email
( ) -	( ) -	

To the best of my knowledge, the information provided in this form is true and complete.

Signature of the authorized person: **Date:**

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

PRINT NEW REQUEST