Desjardins Insurance
LIFE • HEALTH • RETIREMENT

PO Box 1024 STN A
Toronto ON M5W 1G5

Tel.: 604-718-4422 or 1-877-718-4422
Fax: 604-678-8124 or 1-855-678-8124

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

GROUP INSURANCE - DISABILITY CLAIMS

EMPLOYEE'S STATEMENT — LONG TERM DISABILITY

Policy Number 647049

I authorize my employer to maintain a copy of this form: ☐ **Yes** ☐ **No**

Signature of the employee:

Please complete and submit this form when you have been absent from work due to disability for a period of 38 to 42 weeks to your employer or Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, at: **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. This form must be completed in full and sent promptly to avoid delays in the processing of the claim. Any questions should be directed to Desjardins Insurance at: 604-718-4422 or 1-877-718-4422.

SECTION 1 General information

Name of employer		Certificate, Identification or Payroll number
Last name and first name of employee		Social insurance number
Address - No. street, apt.	City	
Province	Postal code	Home telephone number ( ) -
Gender ☐ **Male** ☐ **Female**	Occupation	Date of birth YYYY MM DD

SECTION 2 Information about your claim

Please describe your present illness or injury:

Please describe how your disability prevents you from working. Please include a list of which duties of your job you are unable to perform:

Please list names and phone numbers of all attending physicians and specialists you have seen for this illness or injury and physicians and specialists you are being referred to:

Physician name	Phone no.
	( ) -
	( ) -
	( ) -

SECTION 2 Information about your claim (Continued)

Have you worked anywhere since your illness or injury began? ☐ **Yes** ☐ **No** If Yes →

If yes, please describe:

SECTION 3 Your income from other sources

The maximum you can receive from all sources is 80% (70% for members of Nanaimo Forest Products Ltd.) of your pre-disability basic wage. Please list any amounts of money you are currently receiving or expect to receive each month from the following sources:

Source	Have you applied for	Are you receiving or do you expect	Amount per	Insurance company
Disability income from another group or association plan*	Yes ☐ No ☐	Current ☐ Expected ☐	$	
CPP primary disability pension benefits	Yes ☐ No ☐	Current ☐ Expected ☐	$	
Workers' compensation	Yes ☐ No ☐	Current ☐ Expected ☐	$	Claim number:
Wage continuation or pension plan of any employer including the Pulp & Paper Industry Pension Plan	Yes ☐ No ☐	Current ☐ Expected ☐	$	
Disability income arising out of any law or legislation	Yes ☐ No ☐	Current ☐ Expected ☐	$	
Rehabilitative employment	Yes ☐ No ☐	Current ☐ Expected ☐	$	

* Benefits from your own private or individual disability plan are not included.

SECTION 4 Workers' compensation benefits (if applicable)

Have you received a permanent partial disability (PPD) award for this disability?

☐ **Yes** ☐ **No** If Yes →

If yes, when did you receive it? YYYY MM DD

If yes, what was the amount?

If your Workers' Compensation claim has been denied or terminated, have you appealed the decision?

☐ **Yes** ☐ **No**

If yes, when? YYYY MM DD

SECTION 5 Returning to work

Have you discussed returning to work with your employer, either to your own job, your own job with a change in duties, or another position?

☐ **Yes** ☐ **No** If Yes

If yes, please give details:

The payment of your disability claim will be made by direct deposit only.
Please ensure the following section is completed.

SECTION 6 Automatic deposit of your disability payments

Your disability benefit payments will be automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Desjardins Insurance.

Effective: YYYY MM DD , please deposit my disability payments to the following account: ☐ **Chequing** ☐ **Savings**

If you would like deposits made to your chequing account, please attach a sample cheque marked "VOID".

If you would like deposits made to your savings account, please fill in the information below and have it stamped by your financial institution.

Bank name

Bank address

Bank number	Branch number	Account number	Name in which account is held

Signature of the employee: **Date:**

SECTION 7 Personal information management

Desjardins Insurance and PPWC - Employer Trusteed Health & Welfare Plan handle the personal information they have on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Desjardins Insurance. This information is consulted solely by Desjardins Insurance employees and by the administrative agents of the Plan who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2, or contact the Trust Secretary of the Plan at brianmacleod@shaw.ca. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

SECTION 8 Authorization for the collection and communication of personal information

In accordance with the Personal Information Protection Act of B.C. (PIPA), I authorize Desjardins Insurance, the Plan and its administrative agents, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b)communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

I authorize Desjardins Insurance to use or communicate my social insurance number for administrative purposes.
A photocopy of this authorization is as valid as the original.

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

Signature of the employee: **Date:**

PRINT NEW REQUEST