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 — WEEKLY INDEMNITY

Policy Number 647049

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

Signature of the employee:

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, 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. 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
Name of attending physician(s) / Date first treated YYYY MM DD	Date last worked YYYY MM DD
Name of hospital(s)	

SECTION 2 Information about your claim

Nature of illness or injury

Date you became unable to work due to your disability YYYY MM DD	Date you returned to work if applicable YYYY MM DD

During this period of disability, did you work at any occupation or employment? ☐ **Yes** ☐ **No** If yes →

If yes, please describe:

Is your disability work related? ☐ **Yes** ☐ **No** If yes, has a claim been made for Worker's Compensation? ☐ **Yes** ☐ **No**

Note: If you are suffering a disability for which payment is in dispute with the Workers' Compensation Board, weekly indemnity benefits may be paid retroactively provided you have been off work for two weeks without the Workers' Compensation Board having accepted the claim. You must apply for Workers' Compensation and complete a reimbursement agreement for weekly indemnity benefits to be payable.

SECTION 2 Information about your claim (Continued)

Is your disability due to an accident? ☐ Yes ☐ No

Date and time of accident: YYYY MM DD 00:00 am/pm

Briefly describe how and where the accident happened:

Will you be seeking reimbursement from a third party? ☐ Yes ☐ No ☐ Undecided

Is your disability due to a motor vehicle accident? ☐ Yes ☐ No If yes

If yes, have you notified ICBC? ☐ Yes ☐ No

Note: There is a subrogation provision under the plan and you may be required to complete a reimbursement agreement. In the event you recover an amount from a liable third party for loss of income resulting from the same accident or illness, you must reimburse the plan to the extent that the net third party recoveries plus Weekly Indemnity benefits exceed 100% of your gross wages lost.

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

SECTION 3 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.

YYYY MM DD

Effective: _____ , 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 4 Personal Information Consent

As a member of the Plan I understand that under the Personal Information Protection Act of B.C. (PIPA) I am deemed to consent to the collection, use and disclosure of my personal information for the purpose of my enrolment and coverage under the Plan.

Without limiting that deemed consent, I hereby consent to the collection, use and disclosure by the Plan and its administrative agent, Desjardins Insurance of my personal information contained in this statement, for the purposes of (a) underwriting and administration of coverage; and the ajudication and payment of claims; (b) and for the purposes described in the Plan's Privacy policy.

I further consent to the collection, use and disclosure of my personal information now or subsequently coming into the custody or control of the attending physician(s) or hospital(s) I have listed in this statement which pertain only to the claim I am making herein, including medical records, diagnostic test reports, functional and other types of assessments, clinical notes, x-rays, reports from specialists and my medical prognosis. I further consent to the use of my Social Insurance Number for the purpose of administering this claim and for tax reporting identification purposes. A copy of this authorization shall be as valid as the original.

All personal information will be collected, used and disclosed in accordance with the Plan's Privacy Policy available at www.ppwc.ca and Desjardins Insurance's Privacy Policy available at www.lifeinsurance.com. Alternatively a printed copy of the Privacy Policies will be made available upon written request sent to DFS at the address listed above.

Signature of the employee: **Date:**

SECTION 5 Certification and Signature

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:**

Note: The Board of Trustees of the PPWC - Employer Trusteed Health & Welfare Plan, disclose that it is not regulated under the Financial Institutions Act for the self-insured, weekly indemnity benefit.

PRINT NEW REQUEST