Group Life & Health

Disability claim form – initial assessment

Disability claims department

Montréal
P.O. Box 4002 STN B
Montréal, Québec H3B 4M2

Toronto
P.O. Box 4105 STN A
Toronto, Ontario M5W 2P4

Calgary
P.O. Box 1315 STN M
Calgary, Alberta T2P 2L2

Fax: 1-866-645-4180

Please keep the original documents faxed to Standard Life.

Policyholder statement

To be completed by the policyholder. All questions must be answered in as much detail as possible.

Section A – Policyholder information

Name of policyholder *(Employer/Union/Association)*

Name of subsidiary or division *(if different)*

Address *(no., street)*

Section B – Participant information

Surname | Given name(s) | Initiale

Policy no. | Division no. | Class no. | Social insurance number | Certificate no. | Permanent employee? ☐ Yes ☐ No

Nature of request for benefits: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Waiver of premiums ☐ Dismemberment

Was the employee actively at work when the absence began / loss occurred? ☐ Yes ☐ No

If Yes, please provide the date on which this participant was first covered under this policy: *(YYYY/MM/DD)*

If No, please comment.

What was the participant's date of hire? *(YYYY/MM/DD)*

last date of work? *(YYYY/MM/DD)*

If already back at work, what was the start date? ☐ Part-time *(YYYY/MM/DD)* ☐ Full-time *(YYYY/MM/DD)*

What was the participant's main reason for absence:
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident *(not while working)* ☐ Occupational illness or work accident

Please indicate the hours of work in a normal week:

Mon ________ Tues ________ Wed ________ Thur ________ Fri ________ Sat ________ Sun ________

(If shift work, please provide work schedule)

What was the participant's gross weekly salary as of his/her last day of work? $ ____________

Was the participant: ☐ Salaried ☐ Hourly

Personal income tax exemptions:
Federal $ ____________ Provincial $ ____________

Personal income tax claim/deduction code:
Federal ____________ Provincial ____________

Did the participant receive any income during the disability period? ☐ Yes ☐ No

If Yes, please select one of the following:

☐ Vacation ☐ Maternity leave ☐ Employment insurance ☐ Sick days ☐ Statutory holidays ☐ Other ____________

Amount $ ____________ From *(YYYY/MM/DD)* to *(YYYY/MM/DD)*

Has the participant submitted a claim to the following government bodies?
☐ WSIB / WCB / CSST ☐ EI ☐ CPP ☐ QPP (RRQ) ☐ Provincial automobile insurance board

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