



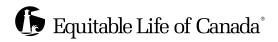
# LONG TERM DISABILITY (LTD) EMPLOYER STATEMENT

The purpose of this form is to enable us to process the claim as quickly as possible and to assist us in evaluating the possibility of providing your employee with rehabilitation assistance, etc. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Policy Number:	ır:		Certificate Number:		Cla	m Number:			
Claimant's Name:									
Employer Nam	ne:								
Job Title:						Length	of time in t	his Job:	
Other Job Posit	tions Held a	t the Employer a	nd Length of Se	rvice:					
Date last worke	Date last worked: Number of hours		Effective date of insurance applicable to this claim			Date insurance terminated			
Is the condition	n due to inju	ry or illness arisir	ng out of employ	/ment?	□ Yes □ No				
		ubmitted to provin correspondence t		mpensati	on plan 🛛 No	□ Ye	es.		
Employee's gro	oss monthly e	earnings: \$			last paid to date:				
Dates covered		Non-Taxable Benefits: Show applicable payroll deductions and check frequency							
					Income Tax				
					EI				
	CPP/QPP								
					Mandatory Pension Plan				
					🗆 Weekly 🗆 Bi-Weekly 🗆 Monthly 🗆 Other				
Has this job been eliminated? 🗆 Yes 🛛 No			If the employee's salary varies or is based on commissions, please include the previous year's T4 slip for Revenue Canada. If this employee receives commissions and/or bonuses, please provide details (i.e. amounts, frequency, etc.)						

If this disability commenced within 12 months of the employee's effective date of long term disability insurance, please answer the following questions.

- a) Was the employee actively at work on a full-time basis for a continuous period of 90 days ending on or after the date on which the employee became insured for long term disability benefits?
- b) Was the employee absent from work, due to disability, during the 12 months prior to the effective date of the employee's insurance?





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c) Did the employee have LT	D coverage with your previou	s carrier?	🗆 Yes	No 🗆 No
If yes, we require a copy Indicate why employee s	of the LTD policy pages an topped working:	d a copy of your fina	l billing from y	your previous carrier.
🗆 Illness	Other (explain)	🗆 Injury	🗆 Laya	off 🗆 Leave of absence
Is there a possibility that you If yes, please explain:	can provide this employee wi	th modified duties?	🗆 Yes	i 🗆 No

# Please attach a copy of the employees job description and Physical Demands Analysis (PDA) to this form and respond to the following questions.

Describe in detail what the job involves including shift work, week-ends, supervisory responsibilities and whether job is dependent upon others or whether their job depends on this employee.

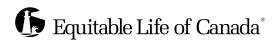
List all types of machines, tools, office equipment and other special equipment this employee uses to do his/her job.

Describe the essential duties of this role.

Describe the work environment with regards to presence of respiratory irritants, noise, humidity, heat, cold, hazards, etc.

#### Review the job ratings below and indicate the appropriate category of this job.

- Sedentary Duties: Exerting up to 10 pounds (4.5 kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary Duties involve sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- □ Light Duties: Exerting up to 20 pounds (9.1 kg) of force occasionally and/or up to 10 pounds (4.5 kg) of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Duties. Light Duties usually require walking or standing to a significant degree. However, if the use of the arm and/or leg controls requires exertion of forces greater than that for Sedentary Duties and the worker sits most of the time, the job is rated Light Duties.
- □ Medium Duties: Exerting up to 50 pounds (22.7 kg) of force occasionally, and/or up to 25 pounds (11.3 kg) of force frequently, and/or up to 10 pounds (4.5 kg) of force constantly to move objects.
- □ Heavy Duties: Exerting up to 100 pounds (45.4 kg) of force occasionally, and/or up to 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects
- □ Very Heavy Duties: Exerting in excess of 100 pounds (45.4 kg) of force occasionally, and/or in excess of 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (91 kg) of force constantly to move objects.





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Please Mark off (x) in the applicable spaces below, those physical activities REQUIRED in this job. PHYSICAL ACTIVITIES REQUIRED TOTAL HOURS PERFORMED DAILY

	Less than 1	1 - 2	3 - 4	5 - 6	7 - 8
LIFTING					
Under 10 lbs/(0.5-4.5 kg)					
10 - 20 lbs/ (5.0-9.1 kg)					
20 - 50 lbs/ (9.5-22.7 kg)					
Over 50 lbs/ (22.8kg)					
CARRYING					
Under 10 lbs/(0.5-4.5 kg)					
10 - 20 lbs/ (5.0-9.1 kg)					
20 - 50 lbs/ (9.5-22.7 kg)					
Over 50 lbs/ (22.8kg)					
reaching					
Above shoulder height					
At shoulder height					
Below shoulder height					
CLIMBING					

In the normal work day, how long would this employee be in the following positions if he/she was doing his/her regular occupation?

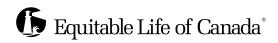
Sitting	hours		Seeir	ng			hours			
Standing	hours		Pushi	Pushing/Pulling			hours			
Walking	hours		Gripp	Gripping hours						
Talking	hours		Pinch	ing			hours			
Hearing	hours		Over	erhead Lifting hours						
Climbing	hours		Keyb	oarding			hours			
Regular hours of work:		Days o	f work week:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
First Break:	From:		To:		•	ŀ	1		ľ	

Please indicate the time period (in months and years) necessary to master activities involved in this job and the general training usually required before such employment can be obtained.

COGNITIVE DEMANDS please check Yes or No in the applicable spaces below

Comprehension	Yes No	Information processing	Yes No
Visual perception	🗆 Yes 🗌 No	Memory	Yes No
Attention	🗆 Yes 🗌 No	Other	Yes No

Please indicate what (if any) modified duties and/or hours are available for this Employee:





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Present Status of employee:	🗆 On disability leave	□ Terminated	□ On Pension	□ Other:
Are you aware of the claimant bei i.e. part-time employment elsewhen			n prior to disability	Ś
If the employee would not be able	e to return to their regular o	occupation, do yc	ou have any alterna	ative job openings?
Are there any circumstances which	would cause you to que:	stion the validity o	f this claim? 🗆 🗅	Yes 🗆 No
Any additional information that ma	ay be helpful in this evalue	ition?		
Date:		Employer Name		
Authorized Name of Employer/Pla Title:	an Administrator (please p	rint): Author	ized Signature of E	mployer/Plan Administrator:
Telephone No.: ( )		Fax No	o.: ( )	
Upload the signed and completed Document Submission Tool located Equitable Life of Canada Group Disability Claims Departme One Westmount Road North P.O. Box 1603 Stn. Waterloo, We	d under the Quick Links se nt	0		38.505.4373 or mail them to:

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