Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
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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: Certificate Number: Claim Number:

Claimant's Name:

Employer Name:

Job Title: Length of time in this Job:

Other Job Positions Held at the Employer and Length of Service:

Date last worked:	Number of hours	Effective date of insurance applicable to this claim	Date insurance terminated

Is the condition due to injury or illness arising out of employment? ☐ Yes ☐ No

If yes, has a claim been submitted to provincial workers compensation plan ☐ No ☐ Yes.
Please forward copies of correspondence to us.

Employee's gross monthly earnings: $ Last paid to date:

Dates covered by salary continuation, sick leave plan(s) or EI or other.	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? ☐ Yes ☐ No

b) Was the employee absent from work, due to disability, during the 12 months prior to the effective date of the employee's insurance? ☐ Yes ☐ No

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c) Did the employee have LTD coverage with your previous carrier? ☐ Yes ☐ No

If yes, we require a copy of the LTD policy pages and a copy of your final billing from your previous carrier.
Indicate why employee stopped working:

☐ Illness ☐ Other (explain) ☐ Injury ☐ Layoff ☐ Leave of absence

Is there a possibility that you can provide this employee with modified duties? ☐ Yes ☐ No
If yes, please explain:

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	Seeing	hours
Standing	hours	Pushing/Pulling	hours
Walking	hours	Gripping	hours
Talking	hours	Pinching	hours
Hearing	hours	Overhead Lifting	hours
Climbing	hours	Keyboarding	hours

Regular hours of work:	Days of work week:	Mon. ☐	Tues. ☐	Wed ☐	Thurs ☐	Fri. ☐	Sat. ☐	Sun. ☐
First Break:	From:	To:						

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 being involved in any other type of occupation prior to disability?
i.e. part-time employment elsewhere or home-based business.

If the employee would not be able to return to their regular occupation, do you have any alternative job openings?

Are there any circumstances which would cause you to question the validity of this claim? ☐ Yes ☐ No

Any additional information that may be helpful in this evaluation?

Date: Employer Name:

Authorized Name of Employer/Plan Administrator (please print): Authorized Signature of Employer/Plan Administrator:

Title:

Telephone No.: ( ) Fax No.: ( )

Upload the signed and completed form via www.equitablehealth.ca using our secure
Document Submission Tool located under the Quick Links section. You can also fax them to 1.888.505.4373 or mail them to:
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One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7

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