

According to your region, please submit the completed form to:

**Quebec**  
PO Box 790, Station B  
Montreal, Quebec H3B 3K6  
Fax: 1-877-799-6691  
disabilitylife@ia.ca

**All other provinces**  
522 University Avenue, Suite 400  
Toronto, Ontario M5G 1Y7  
Fax: 1-877-781-1583  
disabilityclaims@ia.ca

**TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.**

**Type of claim:**    Short-term disability         Long-term disability         Waiver of premium

**1. COVERAGE INFORMATION**

Plan member's first name \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_

Postal code [ ][ ][ ][ ][ ][ ]

Home phone no. [ ][ ][ ][ ][ ][ ][ ][ ][ ] Cell phone no. [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Best time of the day to contact the plan member: AM  PM

Date of birth [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Policy no. \_\_\_\_\_ Certificate no. \_\_\_\_\_ Class no. \_\_\_\_\_ Division no. ( If applicable) \_\_\_\_\_

Plan member's effective date of insurance with iA Financial Group [ ][ ][ ][ ][ ][ ][ ][ ][ ] Service date [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Original effective date of insurance [ ][ ][ ][ ][ ][ ][ ][ ][ ] Date of hire [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Benefits	Current insurance amount
Basic life insurance – Member	
Basic accidental death and dismemberment – Member	
Optional life insurance	
1. Member	
2. Spouse	
3. Children	
Long-term disability – Member	

**2. WORK SCHEDULE AND EARNINGS INFORMATION**

Number of hours worked in a normal week: \_\_\_\_\_

If an irregular schedule, indicate the number of hours worked for each day:

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

Gross salary prior to date of disability: \$ \_\_\_\_\_ Paid monthly  Biweekly  Weekly  Effective date [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Tax credits: Federal (TD1) \_\_\_\_\_ Provincial (TPD1) \_\_\_\_\_

Other, please specify \_\_\_\_\_

During the period of disability, has or will the plan member receive:

Statutory holiday pay  Vacation pay  Pay for sick days  Other  \_\_\_\_\_

Amount \$ \_\_\_\_\_ Period from \_\_\_\_\_ to \_\_\_\_\_

Are you able to accommodate: A gradual return to work  Modified duties

### 3. EMPLOYMENT INFORMATION

Last day worked 

Y	M	D

 Date returned to work (if applicable) 

Y	M	D

Accident at work Yes  No

Was an accident report filed with WSIB, CSST, Worksafe BC, etc.? Yes  No  Date filed 

Y	M	D

On the date the disability commenced was the employee: On vacation  Laid off  On paid leave  On unpaid leave

On disciplinary suspension with pay  On disciplinary suspension without pay  Other  \_\_\_\_\_

If returned to work please specify: Full time  Part time  Regular duties  Modified duties

On the date the plan member last worked, what was the member's:

Occupation \_\_\_\_\_ Please attach a job description if available \_\_\_\_\_

How long has the member worked in this position? Number of years \_\_\_\_\_ Number of months \_\_\_\_\_

If the plan member changed jobs or assignments during the 12 months immediately before the last day worked, describe the previous position and provide the reason(s) for the change in job.

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Please provide any other comments relevant to this claim:

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### 4. WORK DEMANDS INFORMATION

**Please complete or attach a physical demands analysis (PDA)**

During the plan member's normal routine, what percentage of time is he or she required to lift or carry:

	Never	1-25%	26-50%	51-75%	76-100%
More than 10lbs/4.5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 20lbs/9.1 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 50lbs/22.7kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the plan member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How long is the plan member required to remain continuously engaged in the following activities without break:

	0-30 minutes	31-60 minutes	61-90 minutes	more than 90 minutes
Continuous sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Mental demands

During the plan member's normal routine, what percentage of time does the job involve the following activities:

	Never	1-25%	26-50%	51-75%	76-100%
Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tasks with time management pressures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tasks requiring significant attention to detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5. POLICYHOLDER INFORMATION

Policyholder's name \_\_\_\_\_

Address \_\_\_\_\_ Postal code \_\_\_\_\_

Telephone no. \_\_\_\_\_ Extension \_\_\_\_\_

Email address \_\_\_\_\_

I certify the accuracy of the information above.

Authorized person's name \_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_

Signature

If policyholder unable to provide information regarding plan member's work performance or job duties, please provide appropriate contact.

Name \_\_\_\_\_

Telephone no. \_\_\_\_\_ Extension \_\_\_\_\_

Email address \_\_\_\_\_