



Employer's Statement

Claim for Long-Term Disability Benefits

This form has two parts.

Part 1 asks for information on the employee's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Part 2 asks for information on the employee's specific job duties. This part should be completed by the employee's immediate supervisor.

Western Life Assurance Company must receive this form before we can assess the claim. Please send it at least 8 weeks before the end of the elimination period or benefits could be delayed.

Part 1: Employment and Insurance Information

Employer Information

Company Name		
Street Address		
City	Province	Postal Code
Telephone No. ()	Policy/Group Number	ID Number

Employee Information

Last Name	Given Name	Date of Birth / /
Street Address		Apt. No.
City	Province	Postal Code
Home Telephone No. ()	Employee Number	Social Insurance Number

Employment Information

1. When was the employee first hired?

Day	Month	Year
-----	-------	------

2. Employment class (check one box in each row)

a. Full-Time Part-Time ➤ How many hours per week? _____

b. Permanent Temporary Seasonal

c. Hourly Salaried Commissioned

3. Is the employee involved in shift work? No Yes ➤ If Yes, what is the rotation schedule?

4. What was the last day the employee worked before the disability began?

Day	Month	Year
-----	-------	------

5. Is the employee currently absent for medical reasons? No Yes

Employment Information continued

6. If the employee is absent for another reason (eg. Maternity leave), please give details.

7. Was the employee terminated? No Yes ➤ If yes, on what date?

Day	Month	Year
-----	-------	------

8. Has the employee returned to work? No Yes ➤ If yes, on what date?

Day	Month	Year
-----	-------	------

Coverage Information

Effective date of employee's basic LTD coverage with Western Life	Was the employee a late applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Coverage Class (if any)

1. Has LTD coverage ended? No Yes ➤ If Yes, when?

Day	Month	Year
-----	-------	------

2. Have LTD premiums ended? No Yes ➤ If Yes, when?

Day	Month	Year
-----	-------	------

Earnings and benefit information
If any of the questions do no apply, please put N/A.

Gross monthly earnings as of last day worked (exclude overtime, commissions and bonuses) \$ _____	Average monthly commissions earned in the last 24 months. \$ _____
Total personal income tax exemptions according to last TD1 \$ _____	Total personal income tax exemptions according to last TPD1 (Quebec residents only) \$ _____

1. On what date did (or will) the employee's salary end?

Day	Month	Year
-----	-------	------

2. Does the employee have unused sick leave? No Yes ➤ If yes, how many days? _____

3. Does the employee currently receive remuneration from you?

No Yes ➤ Answer a. and b. below

a) How much? \$ _____ per week Does this amount include unused sick leave? No Yes

b) Until what date will remuneration continue (including sick leave credits)?

Day	Month	Year
-----	-------	------

4. According to your records, what is the LTD benefit amount? _____ per month

5. Employees percentage of LTD premium contribution Employee _____ % Employer _____ %

6. Is the employee a member of a retirement or superannuation plan?

No Yes ➤ Registration No _____

7. What amount, if any, will the employee receive under your retirement or pension plan? \$ _____

8. What amount, if any, will the employee receive from CPP, QPP or any other government sponsored plan?

\$ _____

9. Is the employee eligible for early retirement/unreduced pension? No Yes ➤ Give details below

On what date?

Day	Month	Year
-----	-------	------

 Has the employee applied? No Yes

**Workers'
Compensation**

Is the employee entitled to Workers' Compensation Benefits?

No Yes ➤ Provide details in a. through d. below.

a) Has the employee applied? No Yes ➤ Has a decision been made? No Yes

b) What is the amount of benefit received or expected? \$ _____

c) When did (or will) the benefit start?

Day	Month	Year
-----	-------	------

d) When did (or will) the benefit end"?

Day	Month	Year
-----	-------	------

**Declaration for
Part 1**

The information given in Part 1 of this form is true and complete

Name <i>(Please print)</i>	Signature
Title Date	
Telephone No. Fax No. () ()	

PLEASE SEE PART 2 ON NEXT PAGE

Part 2: Information About the Employee's Disability and Job
(to be completed by employee's immediate supervisor)

Information about the disability and rehabilitation
 Attach extra sheets if necessary

Day	Month	Year
-----	-------	------

- When did the employee's illness or injury first appear to affect his or her work?
- From your observations did the employee's ability to perform their job change?

No Yes ➤ Give details below.

- Were any changes made in the employee's job as a result of the illness or injury?

No Yes ➤ What were the changes? When were they made?

- If the employee could return to work part-time or with a change in duties, would a position be available?

No Yes ➤ Give details below.

Recent job history
 Attach extra sheets if necessary

- What was the employee's job title on the last day worked? _____

- How long has the employee worked in this position?

Years	Months
-------	--------

- Please describe the duties of this job and what percentage of each work week is normally taken with each duty.

Duties	Percentage of work week

- If the employee changed occupations or assignments during the 12 months immediately before the last day worked, describe the previous occupation or assignment, give the reason for the change and the effective date of the change.

**Recent
Job History
continued**

5. Please give dates and details of any sick leave, maternity leave, or lay-off during the 12 months before the disability began.

Type of Leave	Details	Beginning Date	End Date

**Work environment
and job activities**

1. Does the employee's job require work in any of the following conditions:

- outside No Yes > If Yes, what percentage of time? _____
- in extremes of cold or heat No Yes > If Yes, what percentage of time? _____
- in a damp or humid environment No Yes > If Yes, what percentage of time? _____
- in a noisy environment No Yes > If Yes, what percentage of time? _____
- in a dusty or unventilated environment No Yes > If Yes, what percentage of time? _____
- around toxic fumes No Yes > If Yes, what percentage of time? _____

2. Does the employee's job involve handling chemicals?

No Yes > If Yes, please list the chemicals below

3. During the employee's normal routine, what percentage of time does the job require the employee to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
more than 50 lbs/22.7 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
more than 20 lbs/9.1 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
more than 10 lbs/4.5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the employee's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 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: daytime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
night-time	<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"/>
at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

Work environment and job activities continued

5. How much time is the employee required to maintain the following activities before changing position or activity?
- | | 0 to 30 minutes | 30 to 60 minutes | 60 to 90 minutes | more than 90 minutes |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| sitting at one time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| standing at one time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| driving at one time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. During the average day, which is the number of hours the employee spends in the following positions or activities
- | | 0 to 2 hours | 2 to 4 hours | 4 to 6 hours | 6 to 8 hours |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| standing | <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"/> |

7. What percentage of the employee's time is spent in the following activities?

Talking	Writing	Supervising Other People
%	%	%

8. Please list any machines, tools, or other equipment that the employee uses in the job. You can either list the number of times per day the equipment is used, or the percentage of time spent using the equipment, whichever is more applicable.

Type of Equipment	No. of Times Per Day <u>OR</u> Percentage of Time

Additional Information

Please provide any additional information that may be relevant to this claim which has not been previously provided.

Declaration for Part 2

To the best of my knowledge, the information given in Part 2 of this form is true and complete.

Name <i>(please print)</i>		Signature
Title	Date	
Telephone No. ()	Fax No. ()	

PERSONAL INFORMATION CONSENT:

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Western Life Assurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@westernlife.com or by calling 1-888-647-5433 and asking to speak to the Privacy office.

Please send this form with all forms you received from the employee to: "

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