

APPLICATION FOR GROUP LONG TERM DISABILITY BENEFITS

Employer's Statement (Please Print)

Please answer all questions

Note: Please certify current employment status and Long Term Disability coverage by completing and signing this portion of the application. If the employee appears to be entitled to Canada/Quebec Pension Plan Disability Benefits, have the employee submit an application.

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------|-------------|--------|--------------------------------------------------|------------------------------------------------------------------------------------|
| Policy/ Plan No. | Account No. | S.I.N. | <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Waiver Group Life Insurance Premium (if applicable) |
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | | | | |
| last name | | | first name | |

CLAIMANT INFORMATION:

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------|
| Date of Birth | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | If age 60 or over, copy of birth certificate must be enclosed with claimant's statement. | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Telephone Number | <input type="text"/> - <input type="text"/> <small>Day Month Year</small> |
| Address | | | | | |
| No. & Street | | Suite/Apt. No. | City/Town | Province | Postal Code |
| Occupation: (State occupation held just before stopping work) | | | | | |
| 1. Is the employee currently absent for medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 2. If the employee is absent for another reason (e.g., maternity leave, leave of absence), please give details. | | | | | |
| Is condition due to injury or illness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If "Yes" has the employee applied for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please provide details: | | | | | |
| | | | | | |

NOTE: If illness/injury is claimed to be work related, the employee must make application to the Worker's Compensation Board for benefits.

COVERAGE INFORMATION:

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| Date of employment: | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | Date employee became <i>insured</i> under: | If employment now terminated, please indicate effective date: |
| | | The Co-operators LTD policy | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>DD MM YY</small> |
| | | With a previous carrier's LTD policy | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>DD MM YY</small> |
| Date last worked: | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | Date expected to return to work: | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> |
| Date returned to work: | | | |
| <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | | | |
| Class/Group/Union affiliation to which claimant belongs (if applicable) _____ | | | |
| <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contract (please enclose a copy of the contract agreement) Average hours worked per week _____ (excluding overtime) | | | |
| <input type="checkbox"/> Temporary <input type="checkbox"/> Commissioned Is the employee involved in shift work? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what is the rotation schedule?) | | | |

Please enclose copy of enrollment card.

EARNINGS/BENEFIT INFORMATION:

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------|
| State employee's pay schedule: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually | | Work Week i.e. Mon. - Fri. _____ |
| State rate of earned gross income immediately before stopping work, based on above pay schedule \$ _____ (exclude overtime, commissions and bonuses) | | Date above rate became effective |
| | | <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> |
| State payroll deduction immediately before stopping work, based on above pay schedule * Please attach copy of paystub for last full pay period. * | | |
| Income Tax \$ _____ | QPP/CPP \$ _____ | EIC \$ _____ Pension (if applicable) \$ _____ RRSP (if applicable) \$ _____ |
| Is any portion of the LTD premium paid for by the policyholder/employer? <input type="checkbox"/> Yes (taxable) <input type="checkbox"/> No (non taxable) | | |
| Current tax exemption per Federal TD1: \$ _____ (attach TD1). | | |
| On what date did (or will) the employee's salary end? | | |
| <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | | |
| Does the employee currently receive remuneration from you? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes answer a & b below) | | |
| a. How much? \$ _____ Per hour Does this amount include unused sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| b. Until what date will remuneration continue (including sick leave credits)? | | |
| <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day Month Year</small> | | |

For commissioned or self employed provide T4, notice of assessment, and statement of expenses for previous two years.

Employee Name: _____

OTHER INCOME:

| | | | |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sick pay from _____ to _____ Day Month Year Day Month Year | <input type="checkbox"/> Short Term Disability from _____ to _____ Day Month Year Day Month Year Paid by (name source) _____ | <input type="checkbox"/> Worker's Compensation from _____ to _____ Day Month Year Day Month Year Status _____ | <input type="checkbox"/> EIC from _____ to _____ Day Month Year Day Month Year Status _____ |
| <input type="checkbox"/> CPP Date applied _____ Status _____ <input type="checkbox"/> QPP _____ Day Month Year | | | |

PENSION INFORMATION (if applicable)

At the date of disability, was the employee a member of one of the following plans? Yes No
 Defined Benefit Pension Plan Defined Contribution Pension Plan Group RRSP Individual RRSP

Administered by (name and address): (i.e. financial institution or organization)

Note: If contributions made to Group or Individual RRSP, please provide copy of Locked-In Agreement.

Date employee became or will become eligible to contribute: _____
Day Month Year

Plan Name _____ Registration/Account Number _____

Contribution levels at date of disability Employee _____% Employer _____%

Total contributions made to the Plan this year Employee _____\$ Employer _____\$

INFORMATION ABOUT THE DISABILITY AND REHABILITATION(attach extra sheets if necessary)

When did the employee's illness or injury first appear to affect his or her work? _____
Day Month Year

From your observations did the employee's ability to perform their job change?

Were any changes made to the employee's job as a result of the illness or injury? Yes No (If yes give details)

What were the changes and when were they made?

If the employee could return to work part-time or with a change in duties, would a position be available? Yes No (If yes, give details)

Have you discussed a return to work with your employee? Yes No If "Yes", have you discussed a return to work at:
Own Occupation Full-time Date _____ Part-time Date _____ **OR**
New Job/Duties Full-time Date _____ Part-time Date _____
 No If "No", please explain: _____

RECENT JOB HISTORY

GROUP POLICYHOLDER/EMPLOYER

Please complete this form based on the claimant's job duties immediately before he/she stopped working

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Position held: _____ | |
| Total number of hours worked per week (include regular overtime) _____ | |
| 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. _____ | |
| Has this job been eliminated? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments or additional information: _____ | |

