



Short Term Disability

SECTION 1 - TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Plan Sponsor - Name _____ Policy #/Division/Class **OR** Control # _____

Plan Member - Last Name _____ First Name and Initial _____ Employment Date (dd/mm/yy) _____ Insurance Effective Date (dd/mm/yy) _____

1. Reason for leaving work (check one):

- Disability Leave of Absence Strike Temporary Layoff
- Dismissed Quit Retired

2. Last day worked _____ (dd/mm/yy) Number of hours worked that day _____

3. If Insurance coverage has terminated, please give date _____ (dd/mm/yy)

Reason _____

4. Is condition due to work related accident or illness? No Yes Has claim been filed with WCB/WSIB/CSST? No Yes

If Yes, Claim # _____ If work related but no claim filed, please provide reason _____

5. Plan member's current basic weekly earnings \$ _____

- Tax Exempt Basic Other (Tax code _____)

6. Hourly rate of pay \$ _____ Regular hours per week _____ Rate of benefit \$ _____

7. Please indicate normal weekly working days:

- Monday Tuesday Wednesday Thursday Friday Saturday Sunday

If non standard cycles, please describe _____

8. Has payment been made (or will be made) to plan member for any vacation days or holidays during the period being claimed? No Yes

If yes, provide dates _____ (dd/mm/yy)

9. Do you expect plan member to return to work? No Yes If yes, approximate date _____ (dd/mm/yy)

10. Is modified or part time work available? No Yes

11. Prior to the last day worked, was plan member currently working: Full Time Full time on modified duties
 Part Time Part time on modified duties

12. If modified, from what date _____ (dd/mm/yy) Was it as a result of work related absence? No Yes

13. Please provide a brief job description _____

14. If disability benefits are payable from any other source, please identify and state amount

Source _____ Amount of Benefit \$ _____

15. Please furnish any other information you believe is pertinent to this claim _____

The plan member is eligible and insured under the provisions of the Master Policy and as indicated by the additional information shown above.

Name of Authorized Plan Administrator _____ Signature _____

Title _____ Date _____
(dd/mm/yy)

SECTION 2 - TO BE COMPLETED BY THE PLAN MEMBER

Plan Member - Last Name		First Name and Initial		Policy #	ID Number
Plan Member - Address	No.	Street	City	Province	Postal Code
SIN Number		Date of Birth (dd/mm/yy)		Phone Number	Email Address
Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			

1. What are the duties of your usual job? _____

_____ Job Title _____

2. On what date were you first unable to work? _____ at _____ A.M. P.M.
(dd/mm/yy)

On what date do you expect to return to work? _____
(dd/mm/yy)

3. Have you discussed modified duties or a part time return to work with your physician? No Yes

What was his/her response? _____

4. Is disability due to an accident? No Yes If yes, please answer the following questions:
- (a) When did it happen? _____ at _____ A.M. P.M.
(dd/mm/yy)
- (b) Where did it happen? at home at work elsewhere (name place) _____
- (c) How did it happen? _____

- (d) Was the accident reported to the police? No Yes If yes, please provide name of police officer and address of detachment and provide copy of police report. _____

- (e) Are you taking action against a third party? No Yes If yes, please provide your lawyer's name and address _____

5. List names and addresses of physicians (other than the physician who completed the claim form) who have treated you in connection with this condition _____

6. Have you been hospitalized for this condition? No Yes
If yes, date hospitalized _____ to _____
(dd/mm/yy) (dd/mm/yy)
Hospital Name: _____
7. Have you (or will you) applied for any other disability benefits from any other source as a result of this condition?
 No Yes If yes, please provide the name of the source _____

SECTION 3 - DECLARATION AND AUTHORIZATION

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize The Maritime Life Assurance Company ("Maritime Life") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Maritime Life will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where Maritime Life deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with Maritime Life, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize Maritime Life and the following persons, institutions and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I understand that any Personal Information that I provide, or which Maritime Life has collected, will be kept by Maritime Life in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Maritime Life and other persons (corporate or individual), firms or agencies engaged by Maritime Life, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law. I understand that where Maritime Life has obtained sensitive medical information from someone other than my physician, Maritime Life will only release such information through my physician. I acknowledge that more detailed information concerning how and why Maritime Life collects, uses and discloses my personal information is available at www.maritimelife.ca, or by requesting a copy from my plan sponsor.

I hereby authorize the use of my Social Insurance Number for the purpose of administering this claim and for tax reporting identification purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, or services for this claim are required for Maritime Life. A copy of this authorization shall be as valid as the original.

Signature of Plan Member (in full) _____

(dd/mm/yy)