Insured's Statement for Disability and Waiver Claim

General Information

1 Insured Information

PLEASE PRINT CLEARLY

Name | Date of Birth D D / M M / Y Y Y Y | ○ Male ○ Female

Policy Number(s) | Do you use nicotine products? ○ Yes ○ No

HOME ADDRESS

Address | Apt./Suite

City | Province | Postal Code

Telephone | Cell Phone | Fax

Email Address | Occupation

BUSINESS ADDRESS

Business Name or Name of Employer | Date of Hire D D / M M / Y Y Y Y

Address | Apt./Suite

City | Province | Postal Code | Contact Person

Website | Telephone | Fax

At which address and telephone number would you prefer to be contacted? ○ Home ○ Business

2 Disability Details

a) Please describe the nature of your condition(s): _____

b) What were your first symptoms? _____

c) When did these symptoms first appear? Date: D D / M M / Y Y Y Y

d) When did you first receive treatment from a physician? Date: D D / M M / Y Y Y Y

e) Last day worked? Date: D D / M M / Y Y Y Y

f) When were you first unable to work? Date: D D / M M / Y Y Y Y Time: _____ ○ AM ○ PM

g) Have you had this condition or a similar type of condition before? ○ Yes ○ No
If ***"Yes"***, please provide additional details and dates: _____

h) Prior to stopping work, did your condition require you to change the way in which you performed your occupational duties? ○ Yes ○ No
If ***"Yes"***, please explain and provide the applicable time frame(s) of these changes: _____

3 If absence is due to injury, please complete the following:

a) What type of injury or injuries did you suffer? ______________________

b) How did this occur? ______________________

c) Date of Injury? Date: DD / MM / YYYY

d) Is any legal action being contemplated or taken against a third party in connection with this injury? ○ Yes ○ No
If ***"Yes"***, please provide additional details, names and dates: ______________________

e) Please attach a copy of the police report if applicable.

4 Treatment

a) If you received treatment at a hospital, institution or rehabilitation facility, please provide details in this section:

Name of hospital, institution or rehabilitation facility		Date admitted	Date Discharged
		DD / MM / YYYY	DD / MM / YYYY

Address	Apt/Suite

City	Province	Postal Code	Telephone

b) Please provide the name and address of each physician or other health care provider involved in your medical care and rehabilitation:

Name and Specialty	
Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit	Frequency of Visits	Date of Next Visit	Fax
DD / MM / YYYY		DD / MM / YYYY	

Name and Specialty	
Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit	Frequency of Visits	Date of Next Visit	Fax
DD / MM / YYYY		DD / MM / YYYY	

Name and Specialty	
Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit	Frequency of Visits	Date of Next Visit	Fax
DD / MM / YYYY		DD / MM / YYYY	

c) If you were recently confined to your home because of disability, please provide dates: ______________________

d) Please describe your current treatment (e.g., surgery, physiotherapy, counselling): ______________________

e) If your treatment includes any complementary or alternative medicine, please provide details: _____

f) If you are taking any prescription or over-the-counter medications, please provide the following details:

NAME OF MEDICATION	DOSAGE & FREQUENCY	DATE STARTED	PURPOSE OF MEDICATION
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	

Have there been any changes to the dosages indicated above? ○ Yes ○ No

If ***"Yes"***, please provide details: _____

g) List pharmacies where you fill your prescriptions:

NAME OF PHARMACY	ADDRESS	TELEPHONE NO.

h) If you are scheduled for any further referrals, blood tests, x-rays, examinations, surgery, or any other type of investigation or treatment, please provide details:

TYPE OF REFERRAL, INVESTIGATION OR TREATMENT	DATE SCHEDULED	HEALTHCARE PROVIDER OR FACILITY
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

i) Please comment on whether treatment to date has been helpful in eliminating, reducing or helping you to cope with your symptoms:

_____

_____

j) Are you satisfied with the treatment you are currently receiving? ○ Yes ○ No

If ***"No"***, what other treatment options are you considering? _____

_____

_____

k) Overall, how would you most appropriately describe your current condition?

○ Recovered ○ Improved ○ Unchanged ○ Deteriorating

5 Functional Self-Report

a) What are you presently able to do? _____

_____

_____

b) How does your condition affect your day to day activities? _____

_____

c) Please list and comment on only those symptoms which affect your ability to work:

SPECIFIC SYMPTOM

1.	IF APPLICABLE, PLEASE COMMENT ON LOCATION, DURATION, FREQUENCY AND SEVERITY OF THIS SYMPTOM
2.	IF APPLICABLE, PLEASE COMMENT ON LOCATION, DURATION, FREQUENCY AND SEVERITY OF THIS SYMPTOM
3.	IF APPLICABLE, PLEASE COMMENT ON LOCATION, DURATION, FREQUENCY AND SEVERITY OF THIS SYMPTOM
4.	IF APPLICABLE, PLEASE COMMENT ON LOCATION, DURATION, FREQUENCY AND SEVERITY OF THIS SYMPTOM
5.	IF APPLICABLE, PLEASE COMMENT ON LOCATION, DURATION, FREQUENCY AND SEVERITY OF THIS SYMPTOM

6 Returning to Work

a) Have you returned to work? ○ Yes ○ No

If ***"Yes"***, when? D D / M M / Y Y Y Y _____ hours/week ○ Part-time ○ Full-time

b) Are you able to do any other work? ○ Yes ○ No If ***"Yes"***, please describe: _____

_____

c) If you have not returned to your pre-sickness/injury work schedule, when do you think you will be able to do so?

○ I do not anticipate returning to work on either a part-time or full-time basis.

○ I anticipate returning to part-time work on or around this date: D D / M M / Y Y Y Y at about _____ hours/week.

○ I anticipate returning to full-time work on or around this date: D D / M M / Y Y Y Y

d) What specific occupational duties are you unable to perform as a result of your condition and what prevents you from performing them?

_____

_____

_____

e) What do you feel has to improve for you to return to work or increase the hours you are presently working?

f) What discussions have you had with your physician about when you could return to work or increase the hours you are presently working?

g) What restrictions, if any, has your physician placed on your work activities?

h) Is the person in charge of your medical care also coordinating a return to work plan for you?
○ Yes ○ No If ***"No"***, who is coordinating your return to work plan? _____

i) Is there any type of assistance you need to return to work or increase your schedule that is not being provided by your medical care?
○ Yes ○ No If ***"Yes"***, please describe. _____

j) Would ergonomic modifications to your workplace, changes to your work schedule, and/or receiving transportation assistance help you to return to work or increase your schedule now or in the near future?
○ Yes ○ No If ***"Yes"***, please describe. _____

k) Are there any non-medical issues making it more difficult for you to work?
○ Yes ○ No If ***"Yes"***, please describe. _____

For the duration of your claim for benefits, it is your responsibilty to notify *ivari* immediately of:
- **any work performed, whether or not you have received a wage or remuneration, or**
- **any employment income paid to you or any other person or party as a result of work performed by you.**

7 Sources of Other Income

a) Please indicate whether you are receiving, or have applied to receive, payments from any of these sources:

	RECEIVING	APPLICATION/APPEAL PENDING	NOT ELIGIBLE/APPLICABLE
Canada/Quebec Pension Plan	○	○	○
Workers' Compensation/Safety Board	○	○	○
Other Individual, Group or Association Policies	○	○	○
Salary Continuance or Other Employee Benefits	○	○	○
Creditor Insurance	○	○	○
Continuing Income from Partnership Agreements*	○	○	○
Employment Insurance	○	○	○
Retirement Pension Plan	○	○	○
Waiver of Life Insurance Premiums	○	○	○
Other (specify below)	○	○	○

*Please provide additional information about Partnership Agreements, if applicable.

b) If you are receiving payments from any source listed above, please provide details in this section.

COMPANY/GOVERNMENT AGENCY	POLICY NUMBER	MONTHLY AMOUNT	TYPE OF COVERAGE	CONTACT PERSON
		$		
		$		
		$		
		$		
		$		
		$		

8 Additional Information

Please provide any other information that would be helpful in the assessment of your claim.

Please list any documents that you have attached to this form.

9 Declaration and Authorization

CLAIMANT'S CERTIFICATION:

The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I hereby agree to refund to *ivari*, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

PRIVACY NOTICE:

I understand that the information collected on this claim form, and otherwise in connection with my claim, is required by *ivari*, its reinsurers and authorized administrators (the "Insurer") for insurance purposes. Examples of insurance purposes include: determining whether there is insurance coverage, investigating and administering claims, evaluating my ability to work, co-ordinating benefits with other insurers and fraud detection. For insurance purposes, the Insurer will consult its existing files, may collect additional information from and about me, including background checks, and, where required, exchange information about me with third parties. This collection, use and disclosure of personal information enables *ivari* to administer claim(s).

Your personal information may be used, stored or accessed in other countries and may be subject to the laws of those countries. Information may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in these countries.

For more details about *ivari's* Privacy Policy, please visit us at: **www.ivari.ca**.

A person may refuse to consent to this collection, use and disclosure of personal information. However, in that event *ivari* may be unable to provide claims services and this may result in delays in processing, or denial, of claim(s).

ivari requires a Social Insurance Number for tax related purposes only and shall share it with the appropriate government agencies where required by law.

INSURER AUTHORIZATION:

I authorize the Insurer to collect, use and disclose personal information (including personal health information) about me for insurance purposes.

AUTHORIZATION TO EXCHANGE PERSONAL INFORMATION:

I hereby authorize any person with relevant information about me, including but not limited to any physician or other health care provider, hospital or other health care institution or medically related facility, any insurance company or reinsurance company, accountant(s), employer, workers compensation board or similar plan and any governmental department, to release and exchange with *ivari*, or a representative thereof, all personal information (including personal health information, benefit payment or financial information), about me in its possession that is requested by *ivari* for insurance purposes.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from *ivari*. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

PRINT TO SIGN Claimant signature	PRINT TO SIGN Witness signature
Claimant name ***(Please Print)***	Witness name ***(Please Print)***
Date: D D / M M / Y Y Y Y	Date: D D / M M / Y Y Y Y

TO AVOID DELAYS IN PROCESSING YOUR CLAIM, PLEASE ENSURE THAT ALL SECTIONS OF THIS STATEMENT HAVE BEEN COMPLETED THOROUGHLY

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