Equitable Life of Canada®

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DISABILITY CLAIM - CLAIMANT'S STATEMENT

Name of Claimant (first, middle, last)	Policy Number	Date of Birth (dd/mm/yyyy)	Social Insurance Number (SIN)
Address (street, city, province, postal code)			Phone number

Employer's name	Occupation	Earnings Per Month ($)
Employer's Address (street, city, province, postal code)		

Complete if an ACCIDENTAL injury	Date of injury (dd/mm/yyyy)
How and where did the accident occur? (explain fully)	
Decscribe injuries	

Complete if a SICKNESS	Date sickness began (mm/dd/yyyy)
Nature of sickness	
Decscribe symptoms, limitations	

Have you used tobacco products in the past 12 months? ❑ Yes ❑ No	Type used	Date last used (dd/mm/yyyy)

When did you become totally disabled and unable to do any work? (dd/mm/yyyy)	Were you confined to a hospital? ❑ Yes ❑ No	If yes, name of hospital
Address	Admitted (dd/mm/yyyy)	Discharged (dd/mm/yyyy)

Are you, at the present time, totally disabled and prevented from working: at your usual occupation? ❑ Yes ❑ No	at any other occupation? ❑ Yes ❑ No
If yes, please give details. Explain, in your own words, what prevents you from working and how you spend your time at present.	
If not totally disabled, what work are you now doing and when did you start?	
When do you expect to be able to work at your usual occupation? (dd/mm/yyyy)	When do you expect to be able to work at any other occupation? (dd/mm/yyyy)

What physicians have you consulted during your present disability and for all causes during the last five years?

Name	Address	Dates	Disease or Conditions

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Please check in the block beside each benefit to which you are or may be entitled from other sources.

- ❑ Canada or Quebec Pension Plan
- ❑ Group Insurance income
- ❑ Retirement pension
- ❑ Insured loans (from banks, etc.)
- ❑ Mortgage insurance
- ❑ Other health insurance coverage
- ❑ Car insurance income
- ❑ Other income (specify)
- ❑ Workers' Compensation - WCB-claim # _____

Give details regarding any of the above benefits which you have checked.

Name of source	Amount of benefit	How often paid	Paid from date (dd/mm/yyyy)

I have read the foregoing and the above answers are true and complete to the best of my knowledge and belief. I authorize any employer, insurance company, Workers Compensation Board, Canada Pension Plan, medical prepayment plan, service organization, physician, practitioner or other person; any hospital or other institution to release to or obtain from the Equitable Life Insurance Company of Canada or my employer, any medical or benefit payment information that may be required to establish the validity of this claim, and further authorize said company, person, or organization, to disclose any personal or claim information required for medical case study or review. I will be responsible for charges incurred in obtaining any other necessary, additional information. A photocopy of this authorization shall be as valid as the original.

Date: | Signature: