



## 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)	Email Address		Phone number

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

<b>Complete if an ACCIDENTAL injury</b>	Date of injury (dd/mm/yyyy)
How and where did the accident occur? (explain fully)	<b>Complete if a SICKNESS</b>
Describe injuries	Date sickness began (dd/mm/yyyy)
	Nature of sickness
	Describe symptoms, limitations

Have you used tobacco products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type used	Date last used (dd/mm/yyyy)
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When did you become totally disabled and unable to do any work? (dd/mm/yyyy)	Were you confined to a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	at any other occupation? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Canada or Quebec Pension Plan | <input type="checkbox"/> Insured loans (from banks, etc.) | <input type="checkbox"/> Car insurance income                      |
| <input type="checkbox"/> Group Insurance income        | <input type="checkbox"/> Mortgage insurance               | <input type="checkbox"/> Other income (specify)                    |
| <input type="checkbox"/> Retirement pension            | <input type="checkbox"/> Other health insurance coverage  | <input type="checkbox"/> 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 Equitable® 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:
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**A limitation period provision describes the time period in which you may commence a proceeding for recovery of policy benefits. This time period is set out in provincial insurance legislation or other legislation that applies to your claim.**

Please note: Equitable cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1 800 668 4095.