Equitable™

Head Office
One Westmount Road North
P. O. Box 1603 Stn. Waterloo, Waterloo, Ontario N2J 4C7

TF: 1 800 668 4095 **T:** 519 886 5110 **F:** 519 883 7422
equitable.ca

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)		

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

Complete if a SICKNESS	Date sickness began (dd/mm/yyyy)
Nature of sickness	
Describe 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 information given in this Statement is true, correct, and complete.

The personal information willingly provided by me to Equitable and held in their files will be used by Equitable for the purposes of claims processing and adjudication; improving and developing insurance and/or reinsurance related tools, processes, studies, algorithms, and products; and post-issue auditing. I understand and authorize that for the above purposes the personal information on file about me, the insured person, or this claim is accessible to, and may be exchanged with: authorized employees of, and relevant third parties retained by, Equitable; Equitable's sales distribution network; participating reinsurer(s); other insurance companies; investigative organizations; health care providers, medical professionals, and pharmacies; and any other person or party whom I authorize.

I acknowledge that personal information about me, the insured person, or this claim may be processed and stored outside of Canada and may therefore be subject to the laws of those jurisdictions. If this policy was issued in Quebec, my personal information will be stored outside of Quebec. Further details about Equitable's privacy practices and contact information for Equitable's Privacy Officer are available at www.equitable.ca.

I authorize any employer, insurance company, Workers Compensation Board, Canada Pension Plan, medical prepayment plan, service organization, physician, practitioner or other persons, 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.

Date:	Signature:

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.