NATIONAL BANK
INSURANCE

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CLAIM REQUEST
DISABILITY INSURANCE
Statement of employer or self-employed worker

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IDENTIFICATION OF THE INSURED

First name ____________ Last name ____________ Date of birth (YYYY MM DD) ____________ Gender: ☐ M ☐ F

STATEMENT OF EMPLOYER OR SELF-EMPLOYED WORKER

In order for us to properly assess the insured's claim, please answer all questions in as much detail as possible.

1. Hiring date (employer) or date the company was created (self-employed worker) (YYYY MM DD): ____________

2. Occupation (title) (please attach a description of duties):

Questions 3 to 7 concern SELF-EMPLOYED WORKERS. If you are the EMPLOYER of the insured, please go to question 8.

3. Describe your duties, the number of hours worked per week as well as your responsibilities **before** your disability:

4. Describe your duties and responsibilities **since** your disability:

5. Who is currently managing your company?

   a) First and last name ____________ Telephone No. ____________

   Address (No., street, city, province, postal code) ____________

6. Do you have any employees? ☐ No ☐ Yes If yes, how many: ____________

7. Did you hire new employees to compensate for your absence? ☐ No ☐ Yes If yes, how many: ____________

8. Please indicate the percentage of duties that require physical effort: ____________ are administrative tasks: ____________

   a) Indicate how many times a day the following actions are performed:

LIFTING (including pushing or pulling while staying in one place)		CARRYING (including pushing or pulling while walking)	
☐ 1 - 10 lbs (0.5 to 4.5 kg):	____	☐ 1 - 10 lbs (0.5 to 4.5 kg):	____
☐ 10.1 - 25 lbs (4.6 to 11.3 kg):	____	☐ 10.1 - 25 lbs (4.6 to 11.3 kg):	____
☐ 25.1 - 50 lbs (11.4 to 22.7 kg):	____	☐ 25.1 - 50 lbs (11.4 to 22.7 kg):	____
☐ 50.1 lbs or more (22.8 kg or more):	____	☐ 50.1 lbs or more (22.8 kg or more):	____

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b) Indicate what percentage of the work day involves each action/element:
Occasionally (O): 0-15% of the time / Frequently (F): 16-50% of the time / Continually (C): 51% of the time or more

O/F/C		O/F/C	
____	Sitting	____	Working with others
____	Standing	____	Using manual dexterity
____	Walking	____	Reaching **below** shoulder height
____	Walking on uneven or slippery terrain	____	Reaching **above** shoulder height
____	Crouching	____	Working outside
____	Kneeling	____	Working inside
____	Climbing (ladders)	____	Working in a humid environment
____	Experiencing vibrations	____	Working in extremes of cold or heat
____	Bending	____	Working around toxic fumes

9. Last day worked (YYYY MM DD): ____________

10. Reason for absence from work (holidays, layoff, illness, accident, etc.): ____________

11. Is the disability covered by salary insurance? ☐ No ☐ Yes

   a) If so, give the name of the insurance company: ____________

12. Has a work stoppage taken place over the last 5 years? ☐ No ☐ Yes

   a) If so, please specify the reason and duration as well as the dates of the work stoppage (for each stoppage):

   ____

   ____

13. Does the current disability fall under workers' compensation legislation? ☐ No ☐ Yes

14. Indicate working hours during a regular week:

____	____	____	____	____	____	____
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

15. Date of return to work:

   ____________ Regular work (YYYY MM DD) ____________ Light work (YYYY MM DD)

   ____________ Full time (YYYY MM DD) ____________ Part-time (YYYY MM DD)

16. Name of company: ____________

   ____
   Address (No., street, city, province, postal code)

   ____________ Telephone No Extension No ____________ Fax No. ____________ Name and title in block letters

SIGNATURE

____________ Date (YYYY MM DD) ____________ Signature

Please sign and date any document that you attach.