

GROUP LIFE INSURANCE WAIVER OF PREMIUM APPLICATION

EMPLOYER INFORMATION

Claimant's Name:			
Group Policy No.:		Certificate No.:	
Employer:			
Exact Job Title:			Length of time in this job:
Other Job Positions Held at the Employer and Length of Service:			
Date last worked:	Number of hours:	Date expected to return:	Date returned:
Employee's basic monthly salary on date of disability:		Name of plant or branch where employee works:	
If the employee's salary varies or is based on commissions, please include the previous year's T4 slip for Revenue Canada. If this employee receives commissions and/or bonuses, please provide details (i.e. amounts, frequency, etc.)		Is there a possibility that you can provide this employee with modified or light duties? <input type="checkbox"/> Yes <input type="checkbox"/> No → If 'Yes', please explain.	
Indicate why employee stopped working: <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain): <input type="checkbox"/> Injury <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence			
Present Status of employee: <input type="checkbox"/> On disability leave <input type="checkbox"/> Terminated <input type="checkbox"/> On Pension <input type="checkbox"/> Other:			
Describe in detail what this job involves including shift work, weekends and whether job is dependent upon others:			
Explain how, in your opinion, the disability prevents the claimant from performing any of these duties:			
Is Work: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy			
List all types of machines, tools, office equipment and other special equipment used in this job. Please describe any supervisory responsibilities:			

How may the condition prevent the claimant from using this equipment?

What are the physical activities required in this job with regard to: sight, hearing, speech, lower extremities and upper & lower back/neck?

Provide job description including physical demands if available.

Describe the work environment with regards to: presence of respiratory irritants, noise, humidity, heat, cold, hazards, etc.

Please indicate the time period (in months and years) necessary to master activities involved in this job and the general training usually required before such employment can be obtained.

If the employee would not be able to return to his/her regular occupation, do you have any alternative job openings? Could his/her skills be used in any other type of work at your place of employment?

Are you aware of the claimant being involved in any other type of occupation prior to disability?
i.e. part time employment elsewhere, home based business or volunteer work.

Date:	Employer Name:
Authorized Name of Employer/Plan Administrator (please print):	Authorized Signature of Employer/Plan administrator:
Title:	
Telephone no: ()	Fax no: ()

Please forward completed form promptly to:

Group Life & Disability Claims Department
The Equitable Life Insurance Company of Canada
One Westmount Road North, PO Box 1603 Stn Waterloo
Waterloo, Ontario N2J 4C7