UV INSURANCE

REQUEST FOR DISABILITY BENEFITS

GROUP INSURANCE

IMPORTANT : AS SOON AS AN EMPLOYEE IS ABSENT FROM WORK AND IS ELIGIBLE FOR DISABILITY BENEFITS, OR QUALIFIES FOR WAIVER OF PREMIUM, PLEASE TRANSMIT THIS FORM TO THE INSURER IMMEDIATELY. ANY INITIAL REQUEST SHOULD INCLUDE AN EMPLOYER'S DECLARATION, EMPLOYEE'S DECLARATION AND ATTENDING PHYSICIAN'S STATEMENT DULY COMPLETED AND SIGNED.

SHORT TERM DISABILITY ☐

LONG TERM DISABILITY ☐

WAIVER OF PREMIUM ☐

EMPLOYER'S DECLARATION

GROUP	DIVISION	CLASS	**CERTIFICATE**
NAME OF EMPLOYEE	SURNAME		SOCIAL INSURANCE NUMBER

OCCUPATION
PLEASE INDICATE THE PRINCIPAL FUNCTIONS AND RESPONSABILITIES, AND ATTACH A COPY OF THE JOB DESCRIPTION, IF POSSIBLE.

DATE EMPLOYED (D M Y)	EMPLOYEE'S WEEKLY GROSS SALARY ______ $ REGULAR WEEK HOURS ______	SINCE WHAT DATE (D M Y)

LAST DAY WORKED

FULL TIME	DATE (D M Y)	HOUR ______ A.M. ☐ P.M. ☐	PART TIME	DATE (D M Y)	HOUR ______ A.M. ☐ P.M. ☐

DEDUCTIONS : ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ OTHER : ______

	EXEMPTION CODE	INCOME TAX WITHHELD	CONTRIBUTIONS QPP / CPP	UNEMPLOYMENT INSURANCE
FEDERAL				
PROVINCIAL				

HAS THE EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐ IF YES, INDICATE DATE (D M Y)

HAS THE EMPLOYEE RETURNED TO HIS REGULAR OCCUPATION FOR AT LEAST 20 HOURS A WEEK? YES ☐ NO ☐

IF NO, EXPLAIN : ______

IS THE DISABILITY DUE TO A WORK RELATED INJURY OR ILLNESS? YES ☐ NO ☐

HAS A DISABILITY CLAIM BEEN FILED WITH WORKERS' COMPENSATION BOARD? YES ☐ NO ☐

IF YES, HAS THE CLAIM BEEN ACCEPTED? YES ☐ NO ☐

IS THE CERTIFICATE TERMINATED? YES ☐ NO ☐ IF YES, SINCE WHAT DATE? (D M Y)

IN YOUR OPINION IS THIS REQUEST JUSTIFIED? YES ☐ NO ☐

IF NOT, EXPLAIN ______

DATE	NAME OF EMPLOYER
BY	TITLE

572-A (11-12)

UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.