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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) _____ Telephone No. _____
First and last name

_____ 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 number 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)
 1 - 10 lbs (0.5 to 4.5 kg): _____
 10.1 - 25 lbs (4.6 to 11.3 kg): _____
 25.1 - 50 lbs (11.4 to 22.7 kg): _____
 50.1 lbs or more (22.8 kg or more): _____

CARRYING (including pushing or pulling while walking)
 1 - 10 lbs (0.5 to 4.5 kg): _____
 10.1 - 25 lbs (4.6 to 11.3 kg): _____
 25.1 - 50 lbs (11.4 to 22.7 kg): _____
 50.1 lbs or more (22.8 kg or more): _____

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

_____ Sitting
_____ Standing
_____ Walking
_____ Walking on uneven or slippery terrain
_____ Crouching
_____ Kneeling
_____ Climbing (ladders)
_____ Experiencing vibrations
_____ Bending

O/F/C

_____ Working with others
_____ Using manual dexterity
_____ Reaching **below** shoulder height
_____ Reaching **above** shoulder height
_____ Working outside
_____ Working inside
_____ Working in a humid environment
_____ Working in extremes of cold or heat
_____ 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. _____ Fax No. _____ Name and title in block letters _____

SIGNATURE

_____ **X** _____
Date (YYYY MM DD) Signature

Please sign and date any document that you attach.