NATIONAL BANK
INSURANCE

800 Saint-Jacques Street, office 43511, Montreal, Quebec H3C 1A3
Telephone: 514-871-7500 or 1-877-871-7500 - Fax: 1-866-394-6340

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

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 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): _____

Insurer: National Bank Life Insurance Company.

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. Fax No. Name and title in block letters

SIGNATURE

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

Please sign and date any document that you attach.