NATIONAL BANK
LIFE INSURANCE COMPANY

CLAIM REQUEST
DISABILITY INSURANCE

Insured's statement

LOAN OR CREDIT CARD INFORMATION

Insured - CIS No. | Transit No.

	Loan or card number	Loan or card number
☐ Personal loan		
☐ Mortgage loan		
☐ Commercial loan		
☐ Auto-Choice loan		
☐ LIWME with advance benefits		
☐ MasterCard credit card	→ The claim concerns ☐ Cardholder ☐ Insured spouse	→ The claim concerns ☐ Cardholder ☐ Insured spouse

IDENTIFICATION OF THE INSURED

Surname (maiden name if applicable)

Given name | Sex ☐ H ☐ F | Social Insurance Number

INSURED'S STATEMENT

1- Date of birth (Y M D)

2- Address (no, street, city and province) ______ Postal Code

Telephone No. ( )

3- a) Briefly describe your duties at work ______

b) Explain how your condition prevents you from working ______

c) Date symptoms first appeared (Y M D) d) Last day worked (Y M D)

e) Date you first consulted a physician for this illness or injury (Y M D)

Name and address of the physician consulted: ______

f) If disability caused by an accident, the accident occurred: ☐ At home ☐ At work ☐ Elsewhere

Date of the accident (Y M D) Circumstances of the accident ______

4- Were you hospitalized: ☐ no ☐ yes → specify : date entered (Y M D) date discharge (Y M D)

Name and address of the hospital: ______

5- a) Are you presently: house confined? ☐ no ☐ yes bedridden? ☐ no ☐ yes hospitalized? ☐ no ☐ yes

b) Describe your daily activities since you stop working: ______

c) When do you expect to be able to return to work full time or part time? (Y M D)

6-This section regarding your medical history must be completed entirely in order to avoid a delay in the processing of your claim.

Names and addresses of all physicians or health care professionals (physician, chiropractor, physiotherapist, psychologist, etc.) you consulted and that treated you during **the last five (5) years**. **Please indicate the reason(s) for each consultation, whether or not they are related to your present condition. If no consultations and/or medical treatments, please indicate this clearly in the space provided below**. If more than three (3) consultations, please attached a separate sheet.

Name and address of the physician or health professional	Consultation or treatment dates			Reason of the consultation	Treatment prescribed (medication, chiro, physio, rest, surgery etc.)
	A	M	J		

CONTINUE OVERLEAF

7- What was the highest level of schooling you completed ______________________________

8- Specify your previous work experience ______________________________

INSURED'S SIGNATURE

I, the undersigned, certify that the statements made in this document are true and complete.

SIGNATURE ______________________________ Date Y M D

Please sign and date any other documents you attach.

In order to avoid a delay in the processing of your claim, please make sure that all the questions have been answered properly.

EMPLOYER'S STATEMENT

1- Employee's name ______________________________ **2-** Hiring date : Y M D

3- Occupation : ______________________________
(please attached a description of tasks)

4- Analysis of physical demands of job

Indicate how many time a day the following movements are executed.

LIFTING (including pushing or pulling while staying in one place)

- ☐ 1 - 5 pd (0.5 à 2.3 kg) _____
- ☐ 5 - 10 pd (2.3 à 4.5 kg) _____
- ☐ 10 - 25 pd (4.5 à 11.3 kg) _____
- ☐ 25 - 50 pd (11.3 à 22.7 kg) _____
- ☐ 50 - 100 pd (22.7 à 45.4 kg) _____
- ☐ 100 pd or more (45.4 kg or more) _____

CARRYING (including pushing or pulling while walking)

- ☐ 1 - 5 pd (0.5 à 2.3 kg) _____
- ☐ 5 - 10 pd (2.3 à 4.5 kg) _____
- ☐ 10 - 25 pd (4.5 à 11.3 kg) _____
- ☐ 25 - 50 pd (11.3 à 22.7 kg) _____
- ☐ 50 - 100 pd (22.7 à 45.4 kg) _____
- ☐ 100 pd or more (45.4 kg or more) _____

Indicate the percentage (%) of time spent on each action in one day.

______ % Sitting
______ % Total time on feet
______ % Standing
______ % Walking
______ % Legs only (stairs)
______ % Legs and arms only (ladder)
______ Bending (stooping)
______ % Kneeling
______ % Indoors
______ % Outdoors

______ % Working with others
______ % Working near others
______ % Working alone
______ % R Manual dexterity
______ % L Manuel dexterity
______ % * R Below the shoulders
______ % * L Below the shoulders
______ % * R Over the shoulders
_____ % * L Over the shoulders
* (Has to stretch to an object)
R = Right L = Left

______ % Other (Explain) ______________________________

5- Last day of work of the employee A M J

6- Reason for stopping work (vacancy, lay off, disability, accident) ______________________________

7- Does the disability comes under work accident legislation ? ☐ yes ☐ no

8- Indicate hours of work in a normal week

Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.

9- Date of return to work

Regular Work Y M D   Light work Y M D

Full time Y M D   Partial time Y M D

10- Name of employer ______________________________

Address ______________________________
(No. of street) (City) (Province) (Postal Code)

Telephone No ( )

Name of the authorized person : ______________________________

Date Y M D   Authorized signature ______________________________ Title ______________

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