Insured's Statement for Disability and Waiver Claim

P.O. Box 4241, Station A
Toronto, ON M5W 5R3
ivari.ca

1 Insured Information

Last name	First name	Date of birth (DD/MM/YYYY)	◯ Male ◯ Female

Policy Number(s)	Do you use nicotine products? ◯ Yes ◯ No

CURRENT RESIDENTIAL ADDRESS

Address			Apt./Suite
City	**Province/territory/state**	**Country**	**Postal/zip code**
Home phone	**Mobile phone**	**Business phone**	
Email address	**Occupation**	**Industry***	

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

BUSINESS ADDRESS

Business Name or Name of Employer		Nature of Business	Date of Hire (DD/MM/YYYY)
Contact Person	**Address**		**Apt./Suite**
City	**Province/territory/state**	**Country**	**Postal/zip code**
Website	**Telephone number**	**Email address**	

At which address and telephone number would you prefer to be contacted? ◯ Home ◯ Business

2 Disability Details

a) Please describe the nature of your condition(s): _____

_____

_____

_____

b) What were your first symptoms? _____

_____

c) When did these symptoms first appear? Date: (DD/MM/YYYY) _____

d) When did you first receive treatment from a physician? Date: (DD/MM/YYYY) _____

e) Last day worked? Date: (DD/MM/YYYY) _____

f) When were you first unable to work? Date: (DD/MM/YYYY) _____ Time: _____ ◯ AM ◯ PM

g) Have you had this condition or a similar type of condition before? ◯ Yes ◯ No

If ***"yes,"*** please provide additional details and dates: _____

_____

h) Prior to stopping work, did your condition require you to change the way in which you performed your occupational duties? ◯ Yes ◯ No

If ***"yes,"*** please explain and provide the applicable time frame(s) of these changes: _____

_____

_____

3 If absence is due to injury, please complete the following:

a) What type of injury or injuries did you suffer? ____________________

b) How did this occur? ____________________

c) Date of Injury? Date: (DD/MM/YYYY) ____________

d) Is any legal action being contemplated or taken against a third party in connection with this injury? ◯ Yes ◯ No
If ***"yes",*** please provide additional details, names and dates: ____________________

e) Please attach a copy of the police report if applicable.

4 Treatment

a) If you received treatment at a hospital, institution or rehabilitation facility, please provide details in this section:

Name of hospital, institution or rehabilitation facility			Telephone number
Address			Apt./Suite
City	Province/territory/state	Country	Postal/zip code
Date admitted (DD/MM/YYYY)	Date discharged (DD/MM/YYYY)		

b) Please provide the name and address of each physician or other health care provider involved in your medical care and rehabilitation:

Name and Specialty			Telephone number
Address			Apt./Suite
City	Province/territory/state	Country	Postal/zip code
Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Email address

Name and Specialty			Telephone number
Address			Apt./Suite
City	Province/territory/state	Country	Postal/zip code
Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Email address

Name and Specialty			Telephone number
Address			Apt./Suite
City	Province/territory/state	Country	Postal/zip code
Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Email address

c) If you were recently confined to your home because of disability, please provide dates: ____________________

d) Please describe your current treatment (e.g., surgery, physiotherapy, counselling): _____

e) If your treatment includes any complementary or alternative medicine, please provide details: _____

f) If you are taking any prescription or over-the-counter medications, please provide the following details:

NAME OF MEDICATION	DOSAGE & FREQUENCY	DATE STARTED (DD/MM/YYYY)	PURPOSE OF MEDICATION

Have there been any changes to the dosages indicated above? ○ Yes ○ No

If ***"yes,"*** please provide details: _____

g) List pharmacies where you fill your prescriptions:

NAME OF PHARMACY	ADDRESS	TELEPHONE NO.

h) If you are scheduled for any further referrals, blood tests, x-rays, examinations, surgery, or any other type of investigation or treatment, please provide details:

TYPE OF REFERRAL, INVESTIGATION OR TREATMENT	DATE SCHEDULED (DD/MM/YYYY)	HEALTHCARE PROVIDER OR FACILITY

i) Please comment on whether treatment to date has been helpful in eliminating, reducing or helping you to cope with your symptoms:

j) Are you satisfied with the treatment you are currently receiving? ○ Yes ○ No

If ***"no,"*** what other treatment options are you considering? _____

k) Overall, how would you most appropriately describe your current condition?

○ Recovered ○ Improved ○ Unchanged ○ Deteriorating

5 Functional Self-Report

a) What are you presently able to do? _____

b) How does your condition affect your day to day activities? _____

c) Please list and comment on only those symptoms which affect your ability to work:

Specific Symptom	If applicable, please comment on location, duration, frequency and severity of this symptom
1.	
2.	
3.	
4.	
5.	

6 Returning to Work

a) Have you returned to work? ○ Yes ○ No

If ***"yes"***, when? (DD/MM/YYYY) _____ _____ hours/week ○ Part-time ○ Full-time

b) Are you able to do any other work? ○ Yes ○ No If ***"yes"***, please describe: _____

c) If you have not returned to your pre-sickness/injury work schedule, when do you think you will be able to do so?

○ I do not anticipate returning to work on either a part-time or full-time basis.

○ I anticipate returning to part-time work on or around this date: (DD/MM/YYYY) _____
at about _____ hours/week.

○ I anticipate returning to full-time work on or around this date: (DD/MM/YYYY) _____

d) What specific occupational duties are you unable to perform as a result of your condition and what prevents you from performing them?

e) What do you feel has to improve for you to return to work or increase the hours you are presently working?

f) What discussions have you had with your physician about when you could return to work or increase the hours you are presently working?

g) What restrictions, if any, has your physician placed on your work activities?

h) Is the person in charge of your medical care also coordinating a return to work plan for you?
○ Yes ○ No If ***"no"***, who is coordinating your return to work plan? _____

i) Is there any type of assistance you need to return to work or increase your schedule that is not being provided by your medical care?
○ Yes ○ No If ***"yes"***, please describe. _____

j) Would ergonomic modifications to your workplace, changes to your work schedule, and/or receiving transportation assistance help you to return to work or increase your schedule now or in the near future?
○ Yes ○ No If ***"yes"***, please describe. _____

k) Are there any non-medical issues making it more difficult for you to work?
○ Yes ○ No If ***"yes"***, please describe. _____

For the duration of your claim for benefits, it is your responsibilty to notify ivari immediately of:
- **any work performed, whether or not you have received a wage or remuneration, or**
- **any employment income paid to you or any other person or party as a result of work performed by you.**

7 Sources of Other Income

a) Please indicate whether you are receiving, or have applied to receive, payments from any of these sources:

PAYMENTS FROM	RECEIVING	APPLICATION/APPEAL PENDING	NOT ELIGIBLE/APPLICABLE
Canada/Quebec Pension Plan	○	○	○
Workers' Compensation/Safety Board	○	○	○
Other Individual, Group or Association Policies	○	○	○
Salary Continuance or Other Employee Benefits	○	○	○
Creditor Insurance	○	○	○
Continuing Income from Partnership Agreements*	○	○	○
Employment Insurance	○	○	○
Retirement Pension Plan	○	○	○
Waiver of Life Insurance Premiums	○	○	○
Other (specify below)	○	○	○

*Please provide additional information about Partnership Agreements, if applicable.

b) If you are receiving payments from any source listed above, please provide details in this section.

COMPANY/GOVERNMENT AGENCY	POLICY NUMBER	MONTHLY AMOUNT	TYPE OF COVERAGE	CONTACT PERSON
		$		
		$		
		$		
		$		
		$		
		$		

8 Additional Information

Please provide any other information that would be helpful in the assessment of your claim.

Please list any documents that you have attached to this form.

9 Certification

By signing below, I certify that:

- I am authorized to give instructions in respect of the policy identified on this form.
- The information provided in this form is current, correct and complete.
- I have read and fully understood the contents of this form, and I acknowledge and agree to its terms.

Signature of Claimant

Claimant's name

Date: (DD/MM/YYYY)

Signature of Witness

Witness name

Date: (DD/MM/YYYY)

TO AVOID DELAYS IN PROCESSING YOUR CLAIM, PLEASE ENSURE THAT ALL SECTIONS OF THIS STATEMENT HAVE BEEN COMPLETED THOROUGHLY

10 Notice regarding collection, use and disclosure of personal information – (Privacy Notice)

ivari's Privacy Policy, available at **ivari.ca,** tells you how ivari will handle your personal information as an Insured and/or Claimant. It also tells you about your rights and choices.

In summary:

ivari uses your personal information for the following purposes:

- Verifying your identity;
- Evaluating any forms you submit about the insurance policies you have in place with ivari;
- Administering and servicing the policy;
- Supporting business operations necessary for us to service the policy;
- Conducting investigations and analyzing claims; and
- Complying with our legal and regulatory obligations (such as tax reporting, compliance with anti-money laundering and anti-terrorist financing laws, and prudential and market conduct laws) and/or any legal or regulatory orders (for example, a court order, subpoena) against ivari.

When required as part of our claims analysis, we may also collect your personal information from external sources such as health care facilities or providers, investigative agencies and/or consumer and credit reporting agencies, and others.

When required, ivari may share your personal information with trusted third parties, including service providers retained by ivari to assist in administering ivari policies, ivari's reinsurers; your financial institution, your independent insurance advisor and their supporting associates, market intermediaries, your beneficiaries and assignees, your family physician or treating medical practitioner and other insurance companies to whom a claim for benefits may be submitted.

It is possible that your personal information may be transferred, stored, handled, or processed outside your jurisdiction and that authorities in those jurisdictions may have access to it.

In some cases, you have a **right to withdraw consent** to the use and sharing of your personal information. You also have the **right to see and correct** the information we have about you, and to **obtain information about any fully automated decisions** we make using your information. Mail your written request to: **Chief Privacy Officer, ivari, 200-5000 Yonge Street, Toronto, Ontario M2N 7E9 or email: privacyoffice@ivari.ca.**

You can see ivari's full Privacy Policy online at ivari.ca. Please make sure you read it carefully so that you understand it in full. Please note that we may update this Privacy Policy from time to time.

CONSENT REQUIRED FOR THIS FORM AND POLICY

The following consents are required to proceed with and submit this form to ivari:

1. I give my consent to the collection, use and disclosure of my personal information as described in the **Privacy Notice** and in ivari's Privacy Policy on **ivari.ca.**
2. I authorize ivari to collect my personal information from third parties for the purposes described in and in accordance with ivari's Privacy Policy.
3. If I am giving my consent on behalf of one or more minor Insured(s) (under the age of 18 years in Quebec or under the age of 16 years in all other provinces) to the points above, then I represent that I have authority to consent on behalf of the minor Insured(s).

Signature of **Insured**

Signature of **Claimant**

P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-855-806-5057 • **claimsdepartment@ivari.ca**

The fastest and easiest way to send us your completed and signed forms is through our online tool, *Send documents* on ivari.ca. By using this tool, forms are sent instantly and securely.

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