Insured's Statement for Disability and Waiver Claim

500-5000 Yonge Street
Toronto, ON M2N 7J8
ivari.ca

1 Insured Information

PLEASE PRINT CLEARLY

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	Postal Code
Home phone	Mobile phone	Business phone
Email Address	Occupation	Industry*

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

BUSINESS ADDRESS

Business Name or Name of Employer	Nature of Business	Date of Hire (DD/MM/YYYY)
Address		Apt./Suite
City	Province / Postal Code	Contact Person
Website	Telephone	Fax

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	Date admitted (DD/MM/YYYY)	Date discharged (DD/MM/YYYY)

Address	Apt/Suite

City	Province	Postal Code	Telephone

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

Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Fax

Name and Specialty

Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Fax

Name and Specialty

Address	Apt/Suite

City	Province	Postal Code	Telephone

Date of Last Visit (DD/MM/YYYY)	Frequency of Visits	Date of Next Visit (DD/MM/YYYY)	Fax

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 Declaration and Authorization

CLAIMANT'S CERTIFICATION

The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I hereby agree to refund to ivari, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The personal information provided in this form will form part of the file established and maintained at ivari's head office. The information in your file may be used for the **purposes of investigation and claim analysis**. ivari collects, uses and discloses your personal information as described in the sections of this form the personal information authorization. In addition, we collect your personal information from this form, and any supplementary forms and questionnaires, and from the following **external sources.**

Physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities or medically related facilities; and other insurers and reinsurers; investigation agencies; motor vehicle and driver record authorities in any relevant jurisdictions;employer; workers compensation board or similar plan; any governmental departments; and your independent insurance advisors.

Personal information collected may include information about your health, character, general reputation, personal characteristics, finances, credit and lifestyle. A representative who is employed to collect information may contact you in person or by telephone in connection with this investigation. For more details about the claims analysis process, you may write to us at the **Claims Department**, ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8.

Your personal information may be shared with your independent insurance advisor and the managing general agencies, distributors and market intermediaries and their employees with which your advisor is associated for purposes identified above. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. For example, personal information may be disclosed in response to demands or requests from government authorities, courts or law enforcement in these countries.

We have safeguards to protect your personal information; however, in the event of an unauthorized access, disclosure or use of your personal information, there is a possibility that you may experience: identity theft, negative effects on a credit record, financial loss, embarrassment or damage to reputation. If ivari believes that you face a real risk of significant harm, ivari's Privacy Office will notify you of the data breach and suggest steps to reduce your risk of harm.

For more details about ivari's Privacy Policy, please visit us at: **ivari.ca.**

A person may refuse to consent to this collection, use and disclosure of personal information. However, in that event ivari may be unable to provide claims services and this may result in delays in processing, or denial, of claim(s).

INSURER AUTHORIZATION

I/We authorize the Insurer to collect, use and disclose personal information (including personal health information) about me/us for insurance purposes.

AUTHORIZATION TO EXCHANGE PERSONAL INFORMATION

For the **purposes of investigation and claim analysis**, I/we hereby authorize any person with relevant information about me/us, including but not limited to any physician or other health care provider, hospital or other health care institution or medically related facility, any insurance company or reinsurance company, employer, workers compensation board or similar plan, any governmental department, and any other organization, institution, association or person, to release and exchange with ivari, or a representative thereof, all personal information (including personal health information, benefit payment or financial information), about me/us in its possession that is requested by ivari.

This authorization does not have any expiry date and it will remain valid for as long as I/we am/are claiming eligibility for benefits or services from ivari. I/We, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

PRINT AND SIGN

Claimant name (please print)	Claimant signature	Date (DD/MM/YYYY)
	PRINT AND SIGN	
Witness name (please print)	Witness signature	Date (DD/MM/YYYY)

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

ivari™ 500-5000 Yonge Street, Toronto, ON M2N 7J8 • Telephone: 1-800-846-5970

Print Form Clear Form