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

Employer's Statement Questionnaire

Policy Number: _____ Insured /Annuitant Name: _____

We are currently reviewing a claim for benefits and we need additional information to understand the impact of their condition on their activities. In order to assist us in our assessment, we would appreciate that you answer the following questions. If the space provided is not sufficient, please use additional sheets of paper.

1 What date did they first start working for you? Date: (DD/MM/YYYY) _____

2 Are they still employed by you? ○ Yes ○ No

3 Indicate their occupation. Describe their duties OR provide a job description.

_____

_____

_____

_____

_____

4 Please record the onset date of sickness or injury. Date: (DD/MM/YYYY) _____

5 Were they employed by you at the time they became sick or injured? ○ Yes ○ No If ***"no"***, what was the date of termination and the reason for termination?

Date: (DD/MM/YYYY) _____

_____

_____

_____

_____

6 If injury, did the accident happen at work? ○ Yes ○ No If ***"yes"***, is this a WSIB/WCB claim? ○ Yes ○ No
Please provide WSIB/WCB claim number, if applicable.

_____

_____

7 Are they receiving benefits under any Group Disability Plan? ○ Yes ○ No

a) If ***"yes"***, please list the insurance company name and policy number.

_____

b) Benefits payable $ _____ Date benefits will end. (DD/MM/YYYY) _____

8 What is the date they stopped all work? Date: (DD/MM/YYYY) _____

9 What is the date they resumed light or part-time work? Date: (DD/MM/YYYY) _____

10 What is the date they resumed full-time work? Date: (DD/MM/YYYY) _____

11 What is the expected return-to-work date? Date: (DD/MM/YYYY) _____

12 What is the average monthly earnings in the last taxation year? $ _____

Employer's name _____

Phone _____ Email _____

Address _____

City _____ Province _____ Postal Code _____

_____ _____

Signature Date Signed (DD/MM/YYYY)

_____ _____

Your name Official position

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

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