SUTTON
SPECIAL RISK

Tel: 416.366.2223
Toll Free: 1.800.461.3292
claims@suttonspecialrisk.com

# Proof of Total Disability - Employer Statement

**Please attach:** Photocopy of employee enrollment card as proof of enrollment

## A - IDENTIFICATION

| | | | |
|---|---|---|---|
| Name of Policyholder or Employer | | | Policy Number |
| Amount of Insurance $ | | Amount of Claim $ | |
| First and Last Name of Employee | | | Social Insurance Number |
| Employee Telephone No. | Fax No. | Email | |
| Address of Employee - No., Street, Apt. | City | Province | Postal Code |
| Employer Telephone No. | Fax No. | Email | |
| Effective Date of Coverage (YYYY/MM/DD) | | Class No. | |

## B - GENERAL INFORMATION

| | | | | |
|---|---|---|---|---|
| Current Salary<br>❒ Weekly ❒ Monthly ❒ Every Two Weeks | Amount<br>$ | Salary Effective Date (YYYY/MM/DD) | | Job Status<br>❒ Full Time ❒ Part Time |
| Indicate Days in Normal Work Week<br>❒ SUN ❒ MON ❒ TUES ❒ WED<br>❒ THU ❒ FRI ❒ SAT | Hours Worked Per Week | Premium Paid by<br>❒ Employer ❒ Both<br>❒ Employee | Date of Employment (YYYY/MM/DD) | Occupation |
| Date Last Worked (YYYY/MM/DD) | Reason for Last Date Worked | | | |

Is disability due to an accident? ❒ Yes ❒ No If "Yes", date of accident: (YYYY/MM/DD)

Did or will the employee receive any income during the disability period? ❒ Yes ❒ No If "Yes", indicate below:
(type: Holiday pay, maternity, disability, EI benefits, salary, lump sum, other)

Type: Amount: $ Period:

Has a claim been filed with a government agency? ❒ Yes ❒ No If "Yes", indicate below:

❒ CSST/WCB/WSIB/WHSCC ❒ CPP/QPP ❒ SAAQ (Quebec only) ❒ No Fault (outside Quebec only)

❒ Other, specify: _____
(YYYY/MM/DD)

Date Filed: Date Rendered: Amount: $

Has the employee returned to work? ❒ Yes ❒ No If "Yes", on what date? (YYYY/MM/DD)

Is this person still in your employ? ❒ Yes ❒ No If "No", specify termination date _____ Reason:
(YYYY/MM/DD)

| | |
|---|---|
| Was this person given a record of employment?<br>❒ Yes ❒ No | Are there any work related factors that may have contributed to the employee's disability or had an impact on their return-to-work? ❒ Yes ❒ No If "Yes", please specify: |

**Return Completed Forms to Sutton Special Risk**
33 Yonge St., Suite 400 Box 311
Toronto, ON M5E 1G4

## C - PHYSICAL WORK ENVIONMENT

**Please attach a brief job description if available.**

What are the main duties of the employee's job and how much time is allocated to each one weekly?

| Duties | % | Duties | % |
|---|---|---|---|
| Duties | % | Duties | % |

For the next two questions, FREQUENCY is defined as follows:

**OCCASIONALLY: 0-15% of the times** **FREQUENTLY: 16-50% of the time** **ALWAYS: 51% + of the time**

Does the employee's job require work in any of the following conditions?

| Frequency: | O | F | A | Frequency: | O | F | A | Frequency: | O | F | A |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Outside | ☐ | ☐ | ☐ | In a damp or humid environment | ☐ | ☐ | ☐ | Above or below ground level | ☐ | ☐ | ☐ |
| In extremes of cold or heat | ☐ | ☐ | ☐ | Toxic fume | ☐ | ☐ | ☐ | Handling chemicals | ☐ | ☐ | ☐ |

Does the job involve other hazards? ☐Yes ☐No If "Yes", please list: _____

Check the items below that relate to the employee's job, and complete the information requested.

| Frequency: | O | F | A | Frequency: | O | F | A | Frequency: | O | F | A |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ Standing | ☐ | ☐ | ☐ | ☐ Bending over | ☐ | ☐ | ☐ | ☐ Extending/reaching above head | ☐ | ☐ | ☐ |
| ☐ Walking | ☐ | ☐ | ☐ | ☐ Kneeling | ☐ | ☐ | ☐ | ☐ Climbing | ☐ | ☐ | ☐ |
| ☐ Sitting | ☐ | ☐ | ☐ | ☐ Crouching | ☐ | ☐ | ☐ | ☐ Stairs (No. of steps____) | ☐ | ☐ | ☐ |
| ☐ Keeping one's balance | ☐ | ☐ | ☐ | ☐ Crawling | ☐ | ☐ | ☐ | ☐ Ladders (Height_____) | ☐ | ☐ | ☐ |

| Describe Activity and Specify Frequency and Weight: | O | F | A | Weight: |
|---|---|---|---|---|
| ☐Pushing _____ | ☐ | ☐ | ☐ | ☐Lb☐Kg |
| ☐Pulling _____ | ☐ | ☐ | ☐ | ☐Lb☐Kg |
| ☐Lifting/Carrying _____ | ☐ | ☐ | ☐ | ☐Lb☐Kg |

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

| Type of Equipment | Times per day |
|---|---|
| Type of Equipment | Times per day |

Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitice movements or have short deadlines? ☐Yes ☐No

If "Yes", please specify: _____

Does the employee's job require dexterity? ☐Yes ☐No

If "Yes", please specify: _____

## D - ADDITIONAL INFORMATION

## E - SIGNATURE OF THE AUTHORIZED PERSON

I hereby certify that the above statements made by me are complete, true and correctly recorded.

Printed Name Position

Signature Date (YYYY/MM/DD)