



Group Name: _____
 Policy Number: _____

Short Term Disability (Weekly Indemnity)
 Long Term Disability
 Waiver of Premium

Employee Name: _____
 Last First Initial

Date of Birth: _____
 YYYY MM DD Male Female

Job Title: _____ Telephone: (____) _____

Date Last Worked: _____
 YYYY MM DD Anticipated Return to Work Date: _____
 YYYY MM DD

Nature of Medical Condition: _____
 Comments: _____

Is condition due, or related, to occupational illness or accident (past or present)? Yes No
 Please explain: _____

(If yes, attach copy of workers' compensation correspondence)

Has employee ever submitted an application for similar cause(s)? Yes No
 If yes, include dates paid and insurance carrier:
 From: _____ To: _____ Carrier: _____
 YYYY MM DD YYYY MM DD

Employee's Occupation on Date Last Worked: _____
(Please complete and attach Job Description Form)

Date Returned to Work: _____ Part Time Full Time
 YYYY MM DD

Please indicate dates covered by:

<input type="checkbox"/> Salary Continuation	From: _____	To: _____
	YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Paid Sick Leave	From: _____	To: _____
	YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Paid Vacation	From: _____	To: _____
	YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Other _____	From: _____	To: _____
	YYYY MM DD	YYYY MM DD

Please include employee's claim code from the TD1(E) form: _____

If SELF-BILLED GROUP, please complete: Employee Classification: _____

Date Employed: _____ Employee's Effective Date of Coverage: _____
 YYYY MM DD YYYY MM DD

Earnings as of Date Last Worked:
 hourly _____ hrs/wk Commission Basis
 weekly monthly yearly
 \$ _____
 If Commission Basis, please attach previous year's T4.

This section must be completed by all groups (Please Print)

Name: _____
 Last First Initial

Title: _____ Telephone: (____) _____ Fax: (____) _____

Signature: _____ Date: _____
 YYYY MM DD

