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 ❒ Weekly ❒ Monthly ❒ Every Two Weeks	Amount $	Salary Effective Date (YYYY/MM/DD)		Job Status ❒ Full Time ❒ Part Time
Indicate Days in Normal Work Week ❒ SUN ❒ MON ❒ TUES ❒ WED ❒ THU ❒ FRI ❒ SAT	Hours Worked Per Week	Premium Paid by ❒ Employer ❒ Both ❒ 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? ❒ 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 270 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)