

CLAIM JOB ANALYSIS SELF-EMPLOYED WORKERS

Claimant First Name: Last Name:				
Unique Client ID.:				
Business Name:				
Business Address:				
Business Phone Number:				
Date Business Opened (MM/DD/YYYY): Sole ownership or partnership:				
Nature of Business: Regular work hours per day/week:				
Last day worked at Business (MM/DD/YYYY) Estimated return to work date (full-time/part-time)(MM/DD/YYYY				
Is your Business still in operation:				
If yes, please outline what duties you are still performing, including hours per day and per week worked.				
If no, who is performing your duties in your absence?				
Are you in receipt of any wages or profit from your business since your last day worked?				
Please provide the following details of your business:				
1. Environment: Temperature, Light, Noise, Vapour/Fumes, Physical Hazards, etc.):				
Equipment: Types of machines, equipment, tools and work aids required to perform occupation:				
Vehicles: Vehicles or equipment driven at work: Please specify if a special license is required.				
4. Job Modifications: Can job duties and work hours be modified to accommodate restrictions? If not, plo	ease explain why.			
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5. Work Place Modifications: What physical aids can be provided to accommodate a return to work?				
Loss: Please describe any profit losses or operating costs your business has incurred since your disabilities.	ility began. Have you			
liquidated any assets? Have you declared bankruptcy?				



Claimant First Name:	Last Nam	e:	
Unique Client ID.:			
Please	Physical Demands of the occ e circle / select the appropriate	cupation at the time of disability numbers below for each Job requirem	nent
	3 - frequent and/or rep	ned onally, less than 1 hour per day petitious for 1-3 hours daily uirement for over 3 hours per day	
Sitting Chair	□0 □1 □2 □3 □4	Gripping	□0 □1 □2 □3 □4
Sitting Vehicle Seat	□0 □1 □2 □3 □4	Pinching	□0 □1 □2 □3 □4
Standing	□0 □1 □2 □3 □4	Typing	□ 0 □ 1 □ 2 □ 3 □ 4
Walking:		Climbing:	
Level Surface		Ladders	
Uneven Surface		Scaffolding	
Stairs		Other	
Bending:		Lifting:	
Stooping	□0 □1 □2 □3 □4	From Ground	□0 □1 □2 □3 □4
Crouching	□0 □1 □2 □3 □4	From Waist	□0 □1 □2 □3 □4
Kneeling	□0 □1 □2 □3 □4	Above Waist	□ 0 □ 1 □ 2 □ 3 □ 4
Mobility:		Lifting, Carrying, Pushing, Pulling:	
Carrying		0 to 10 lbs	
Pushing		10 to 25 lbs	
Pulling	□ 0 □ 1 □ 2 □ 3 □ 4	25 to 50 lbs	
Crawling	0 1 2 3 4	Over 50 lbs	
Reaching:			
Below Shoulder			
At Shoulder Level			
Above Shoulder			
Comments:			
Signature:		Date:(M	IM/DD/YYYY)



PROTECTING YOUR PERSONAL INFORMATION

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

- When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information.
- · Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life.
- You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing
 to Canada Life.

Who has access to your information:

- We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access.
- In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada.
- Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

- Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which
 you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data
 management and analytics purposes.
- This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.

The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

This consent may be revoked by me at any time by sending a written instruction. I agree that a copy of this authorization is as valid as the original.

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Signature of Claimant:	Date:
_	(MM/DD/YYYY)

PLEASE SUBMIT COMPLETED FORM TO:

THE CANADA LIFE ASSURANCE COMPANY
CREDITOR INSURANCE
CLAIMS DEPARTMENT

330 University Avenue, Toronto, Ontario, Canada M5G 1R8

Fax No.: 416-552-6557

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