CLAIM JOB ANALYSIS

CLEAR

Claimant First Name:_____ Last Name: _____

Unique Client ID.: _____

To be completed by employer.

Company Name:	
Company Address:	
Employee Hire Date (MM/DD/YYYY):	Last Day Worked (MM/DD/YYYY):
Reason for last day worked:	
Occupation at time of disability:	
Estimated return to work date (MM/DD/YYYY):	
Please provide the following details about the occupation:	
1. **Work Schedule:** Full-time, Part-time, day or night shift and number of hours worked per day and per week.	
2. **Environment:** Temperature, Light, Noise, Vapour/Fumes, Physical Hazards, etc.):	
3. **Equipment:** Types of machines, equipment, tools and work aids required to perform occupation:	
4. **Vehicles:** Vehicles or equipment driven at work: Please specify if a special license is required.	
5. **Job Modifications:** Can job duties and work hours be modified to accommodate restrictions? If so, please provide a date when these modifications would be available.	
6. **Worker Modifications:** What physical aids can be provided to accommodate a return to work?	

Claimant First Name:_____ Last Name: _____

Unique Client ID.: _____

Physical Demands of the occupation at the time of disability
Please circle / select the appropriate numbers below for each Job requirement

0 - never performed
1 - sometimes performed
2 - performed occasionally, less than 1 hour per day
3 - frequent and/or repetitious for 1-3 hours daily
4 - maximum job requirement 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	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	Ladders	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Uneven Surface	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	Scaffolding	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Stairs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	Other	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
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 ☐ 1 ☐ 2 ☐ 3 ☐ 4	0 to 10 lbs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Pushing	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	10 to 25 lbs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Pulling	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	25 to 50 lbs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Crawling	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	Over 50 lbs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Reaching:			
Below Shoulder	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
At Shoulder Level	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Above Shoulder	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		

Comments:

Name: _____ Title: _____

Phone: _____

Signature: _____ Date: _____
(MM/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

E-MAIL ADDRESSES:
WESTERN & NORTHERN PROVINCES: VANCOUVER_CREDITOR@CANADALIFE.COM
ONTARIO: TOR_CREDITOR_CLAIMS@CANADALIFE.COM
QUÉBEC: CREANCES.MONTREAL@CANADALIFE.COM
MARITIME PROVINCES: HALIFAXCREDITOR@CANADALIFE.COM