First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

DISABILITY CLAIM APPLICATION FORMS

For

Standard / Partial Payment and Dismemberment Plans

"INSTRUCTIONS"

ALL OF THE FOLLOWING PROPERLY COMPLETED FORMS ARE ESSENTIAL TO THE PROMPT PROCESSING OF YOUR DISABILITY CLAIM:

- INFORMATION RELEASE FORM
- CLAIMANT'S STATEMENT
- ATTENDING PHYSICIAN'S STATEMENT
- EMPLOYER'S STATEMENT

Please ensure that all the attached forms are fully completed, witnessed where indicated, and that all details listed on the forms are provided by you, your employer and your doctor. (Incomplete forms will be returned for correction, which will delay our claim process and our service to you.)

NOTE: You must also provide the following documents:

- ❑ A copy of your finance contract (For lender/loan verification)
- ❑ A copy of your driver's license (For confirmation/verification of age)
- ❑ A copy of your motor vehicle accident (MVA) report and damage repair estimate (for disabilities arising from an MVA)
- ❑ A copy of your acceptance/denial letter from your provincial workers compensation board (if your injury/illness is work related)
- ❑ A copy of your Record of Employment from your previous occupation (if your current employer differs from your employer on the Effective Date of Insurance)

Before you submit your claim for benefits, please read your Certificate of Insurance carefully; in particular the section entitled "LIMITATIONS AND EXCLUSIONS".

Under conditions of the policy, proof of claim must be submitted to our company on forms supplied by the company within **ninety days** of the event giving rise to the claim, and you must be totally disabled for longer than the waiting period specified on your Certificate of Insurance to claim benefits. If approved, Disability Benefits will be calculated from no earlier than 90 days prior to the date that proof of claim was received. In no event will a proof of claim be considered valid when submitted more than one year after the event giving rise to the claim.

We remind you that it remains your responsibility to continue to make your payments to your Lender until your claim is accepted and approved for payment by us. Our terms of payment as an Insurer will differ from the terms of payment required by your Lender, therefore, we recommend that you contact your Lender to ensure that you do not default on your obligation pending claim settlement.

ALL APPROVED BENEFITS ARE FORWARDED DIRECTLY TO YOUR LENDER.

PROMPT REPORTING OF YOUR CLAIM IS IMPORTANT.
(Immediately following an eligible disability)

UPON RECEIPT OF YOUR COMPLETED CLAIM FORMS WE WILL NOTIFY YOU:

- IF WE NEED MORE INFORMATION
- WHEN YOUR CLAIM IS APPROVED AND PAID
- IF YOUR CLAIM CANNOT BE PROCESSED AND THE REASONS WHY

THE INITIAL EXPENSES REQUIRED FOR PROVIDING THE PROOF OF CLAIM INFORMATION ARE THE RESPONSIBILITY OF THE CLAIMANT

First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

INFORMATION RELEASE FORM

Before First Canadian Insurance Corporation "FCIC" can determine if you are eligible to receive compensation for your disability, it may be necessary that we obtain additional information on your behalf, to assist us in determining eligibility.

This may consist of contacting *physician(s), hospital, or other medical health care professionals*, for personal health information (your medical history) and/or your present treatment, your *provincial health care organization* for an outline of benefits paid, and your pharmacy, for a list of your prescribed medications. We may also, from time to time, contact your *physicians,* or *other medical health care professionals* for updates regarding your condition.

Also, we may be required to contact your present and/or previous employer to clarify your employment status at the time this policy was purchased, details surrounding your job function(s), and verification of a return to work date.

In the case of a Motor Vehicle Accident (or acute injury, if applicable), our office may require details surrounding your accident from the applicable *law enforcement agency* and your *insurance company*.

In all cases, we will need to contact your Lender for loan verification, and updates regarding the status of your account, as all approved benefits are forwarded directly to them to be applied to your loan.

FCIC, in all cases, will advise you when information is requested on your behalf. If you require any clarification regarding the necessity of requesting any information on your behalf, please feel free to contact our Claims Department.

You may withdraw your consent at any time, by advising our office, in writing.

FCIC, under no circumstances (unless required by law) will release the information received as a result of this release to a third party.

I hereby authorize any physician and other medical health care professionals, provincial health care organization, hospital, Lender, employer, law enforcement agency, insurance company, information bureau, or any organization or person with records or knowledge, of the Insured's health and employment, to release the necessary information to First Canadian Insurance Corporation. I authorize the Lender to release a copy of my Finance Contract, Statement of Account as well as loan verification and updates as required. A facsimile or photocopy of this authorization shall be as valid as the original.

_____
Signature of Claimant

_____
Print Name

_____
Date

This Consent is Valid for:
- ❑ The Term of the Policy
- ❑ This Claim only
- ❑ Other _____

_____
Witness Signature

_____
Witness Print Name

_____
Certificate Number
(See Application for Insurance)

First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

CLAIMANT'S STATEMENT

SECTION 1 - INFORMATION ABOUT YOU

FULL NAME	MAILING ADDRESS	DATE OF BIRTH MONTH DAY YEAR **Please supply a copy of your Driver's License**
TELEPHONE *(PLEASE INCLUDE AREA CODE)* HOME ( ) WORK ( )	CITY / PROVINCE	CERTIFICATE NUMBER
EMAIL: DO YOU CONSENT TO CORRESPONDING VIA EMAIL? ❑ YES ❑ NO	POSTAL CODE	PROVINCIAL HEALTH CARE NUMBER
HAVE YOU RESIDED IN THE SAME PROVINCE DURING THE SIX (6) MONTHS PRIOR TO THE EFFECTIVE DATE OF YOUR POLICY? ❑ YES ❑ NO IF NO, PLEASE PROVIDE YOUR PREVIOUS ADDRESS:		

SECTION 2 - DETAILS OF YOUR FINANCIAL OBLIGATION

LOAN DATE MONTH DAY YEAR	AGENT/AGENCY	
LENDER	LENDER ADDRESS	PHONE ( ) FAX ( )
HAS THIS LOAN BEEN RE-WRITTEN OR REVISED? ❑ YES ❑ NO IF SO, PLEASE PROVIDE DETAILS	LOAN NUMBER	MONTHLY PAYMENT
PLEASE PROVIDE A COPY OF THE FINANCE CONTRACT. (IF THERE ARE ANY ADDENDUMS AND/OR REVISIONS, PLEASE INCLUDE THIS DOCUMENTATION.)		
DO YOU HAVE MORE THAN ONE ACTIVE LOAN INSURED THROUGH FIRST CANADIAN INSURANCE CORPORATION? ❑ YES ❑ NO IF SO, YOU WILL NEED TO SUPPLY ALL INFORMATION IN SECTION 2 FOR YOUR OTHER FINANCIAL OBLIGATION(S)		

SECTION 3 - ABOUT YOUR DISABILITY

WHAT IS THE ILLNESS OR INJURY FOR WHICH YOU ARE CLAIMING BENEFITS?		LOCATION OF ACCIDENT ❑ HOME ❑ WORK ❑ ELSEWHERE If elsewhere, please elaborate: _____
WHEN DID THESE SYMPTOMS FIRST APPEAR? MONTH DAY YEAR	WHEN DID YOU FIRST ATTEND YOUR PHYSICIAN FOR THIS CONDITION? MONTH DAY YEAR	HAVE YOU HAD THE SAME OR SIMILAR CONDITION BEFORE? IF SO, WHEN? MONTH DAY YEAR NAME OF TREATING PHYSICIAN: _____
IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE DESCRIBE HOW THE INJURY OCCURRED.		
PLEASE OUTLINE YOUR SYMPTOMS, AND HOW THEY PREVENT YOU FROM RETURNING TO WORK.		

Continued on next page

IS YOUR CLAIM WORK RELATED? ❑ YES ❑ NO IF YES, PLEASE PROVIDE YOUR WCB CLAIM # _____ NAME AND PHONE NUMBER OF ADJUSTER: _____ **PLEASE ALSO SUPPLY A COPY OF YOUR WCB ACCEPTANCE / DENIAL LETTER.**	IF YOUR CLAIM IS WORK RELATED BUT WCB HAS NOT ACCEPTED YOUR CLAIM (OR YOU HAVE NOT SUBMITTED A CLAIM) PLEASE PROVIDE DETAILS REGARDING THIS.
IS YOUR CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? ❑ YES ❑ NO **ENCLOSE A COPY OF THE MOTOR VEHICLE ACCIDENT REPORT AND A COPY OF THE DAMAGE REPAIR ESTIMATE (or PROOF OF LOSS STATEMENT)**	AUTO INSURER NAME: _____ INSURER'S CLAIM NO: _____ ADJUSTER'S NAME: _____ ADJUSTER'S PHONE NUMBER: ( ) _____

NAME OF DOCTOR TREATING THIS DISABILITY WHEN DID YOU BECOME PART OF THIS DOCTOR'S PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
DETAILS OF TREATMENT FROM ANY OTHER FACILITY (ie. Physiotherapy/Chiropractic) WHEN DID YOU BECOME A PART OF THIS PRACTICE?	FACILITY'S ADDRESS CITY PROVINCE POSTAL CODE	FACILITY'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR OF INSURED WHEN DID YOU BECOME A PART OF THIS PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
NAME OF FAMILY DOCTOR ON EFFECTIVE DATE OF COVERAGE WHEN DID YOU BECOME A PART OF THIS PRACTICE?	DOCTOR'S ADDRESS CITY PROVINCE POSTAL CODE	DOCTOR'S TELEPHONE PHONE ( ) FAX ( )
PLEASE LIST THE PHARMACY(IES) WHERE YOU HAVE YOUR MEDICATIONS FILLED 1.	PHONE NUMBER(S)	MEDICATIONS FILLED
2.		
3.		
4.		
WERE YOU HOSPITALIZED? ❑ YES ❑ NO	IF "YES", NAME OF HOSPITAL ***PLEASE PROVIDE A COPY OF THE EMERGENCY ROOM REPORT AND THE DISCHARGE SUMMARY***	DATES HOSPITALIZED FROM TO

PLEASE PROVIDE A LIST OF ALL OTHER INSURANCE COMPANIES FOR WHICH YOU HAVE DISABILITY INSURANCE COVERAGE, INCLUDING ADDRESS, TELEPHONE NUMBER AND CONTACT INFORMATION.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT ALL PHONE CONVERSATIONS WITH FCIC REPRESENTATIVES ARE RECORDED FOR QUALITY ASSURANCE, TRAINING PURPOSES, AND DISPUTE RESOLUTION.

_____ Signature

_____ Date

First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

ATTENDING PHYSICIAN'S STATEMENT

(TO BE COMPLETED BY YOUR PHYSICIAN)

NOTE TO DOCTOR: THIS STATEMENT WILL BE USED TO DETERMINE YOUR PATIENT'S DISABILITY BENEFITS. CLEAR AND COMPLETE INFORMATION AS TO CAUSE, PROGNOSIS AND TREATMENT WILL SPEED PROCESSING OF THE CLAIM

NAME OF PATIENT	DATE OF BIRTH	PROVINCIAL HEALTHCARE NUMBER

WHAT IS THIS PATIENT'S DISABLING CONDITION (DIAGNOSIS)

IS THE PATIENT PREVENTED, BY THE DISABILITY STATED, FROM PERFORMING HIS/HER OCCUPATION? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING

WHEN DID THIS DISABLING CONDITION FIRST PREVENT YOUR PATIENT FROM PERFORMING THE DUTIES OF HIS/HER OCCUPATION?

MONTH DAY YEAR

SYMPTOMS

DOES PATIENT HAVE ANY OTHER MEDICAL CONDITIONS WHICH MAY AFFECT THIS DISABILITY? IF YES, PLEASE EXPLAIN.

PLEASE PROVIDE A BRIEF HISTORY OF CONDITION

HISTORY OF ILLNESS OR INJURY TO THE BEST OF MY KNOWLEDGE, PATIENT'S SYMPTOMS FIRST APPEARED MONTH DAY YEAR	PATIENT WAS MOST RECENTLY SEEN FOR THIS CONDITION MONTH DAY YEAR
PATIENT WAS FIRST SEEN FOR THIS CONDITION MONTH DAY YEAR	PATIENT HAS BEEN PART OF MY PRACTICE SINCE MONTH DAY YEAR

TO THE BEST OF YOUR KNOWLEDGE, HAS THE PATIENT PREVIOUSLY SUFFERED FROM THE SAME OR SIMILAR CONDITION ❑ YES ❑ NO

IF YES, PLEASE PROVIDE THE DATES PREVIOUSLY ATTENDED FOR THIS CONDITION

DID THE PATIENT FULLY RECOVER ❑ YES ❑ NO IF SO, WHEN?

IS THIS CONDITION DRUG RELATED? ❑ YES ❑ NO IF SO, PLEASE LIST THE DRUG(S), AND HOW THEY RELATE.

IS THIS CONDITION ALCOHOL RELATED? ❑ YES ❑ NO

HAS THE PATIENT BEEN REFERRED TO A REHABILITATION PROGRAM? ❑ YES ❑ NO

IF SO, PLEASE LIST THE DATE OF ENROLLMENT EXPECTED DURATION

Continued on next page

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?	❑ YES	❑ NO
IF SO, HAVE YOU COMPLETED ANY FORMS FOR THIS PATIENT FOR WORKERS COMPENSATION?	❑ YES	❑ NO

DESCRIBE FREQUENCY OF ATTENDANCE (EG: WEEKLY, MONTHLY)	LIST ALL DATES ATTENDED FOR THIS CONDITION:

PLEASE PROVIDE THIS PATIENT'S TREATMENT OUTLINE.	IS THIS PATIENT FOLLOWING RECOMMENDED TREATMENT ❑ YES ❑ NO IF NO, PLEASE COMMENT:

PLEASE EXPLAIN THE EXTENT TO WHICH THE PATIENT'S CONDITION AFFECTS CAPACITY TO PERFORM HIS/HER OCCUPATION

DOES PATIENT'S MENTAL OR NERVOUS IMPAIRMENT AFFECT HIS/HER ABILITY TO WORK? (IF APPLICABLE, DISCUSS)

HAS THIS PATIENT BEEN REFERRED TO A PSYCHIATRIST, PSYCHOLOGIST OR NEUROLOGIST? ❑ YES ❑ NO

IF SO, PLEASE PROVIDE THE NAME OF THIS PHYSICIAN, INCLUDING A COPY OF THE REFERRAL LETTER AND ANY CONSULTATION REPORTS.

WHEN DO YOU EXPECT THE PATIENT WILL RECOVER SUFFICIENTLY TO PERFORM MODIFIED / LIGHT DUTIES?	WHEN DO YOU EXPECT THE PATIENT WILL RECOVER SUFFICIENTLY TO PERFORM ALL DUTIES OF HIS/HER OCCUPATION?
IF INDEFINITE, ESTIMATE ❑ 1-3 MONTHS ❑ 4-6 MONTHS ❑ OVER 6 MONTHS	IF INDEFINITE, ESTIMATE ❑ 1-3 MONTHS ❑ 4-6 MONTHS ❑ OVER 6 MONTHS

HAS THIS PATIENT BEEN REFERRED TO A SPECIALIST? ❑ YES ❑ NO IF YES, DATE OF REFERRAL: _____ *PLEASE PROVIDE COPIES OF THE REFERRAL LETTERS AND ANY SUBSEQUENT CONSULTATION REPORTS.*	PLEASE LIST OTHER ATTENDING HEALTH CARE PROFESSIONALS FOR THIS CONDITION (NAME, ADDRESS AND TELEPHONE) *IF THERE ARE ANY REPORTS AVAILABLE FROM THESE SOURCES, PLEASE INCLUDE IN YOUR RESPONSE.*

ADDITIONAL INFORMATION
PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS THAT MAY BE HELPFUL IN ASSESSING YOUR PATIENT'S CLAIM, INCLUDING ANY PHOTOCOPIES OF SUPPORTING DOCUMENTATION (ie. BIOPSIES, XRAY RESULTS etc).

IN YOUR OPINION, WOULD FIRST CANADIAN INSURANCE CORPORATION BENEFIT FROM AN INDEPENDENT MEDICAL EXAMINATION? ❑ YES ❑ NO

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED AT CITY PROVINCE	DATE MONTH DAY YEAR
SIGNATURE OF PHYSICIAN	PRINTED NAME AND ADDRESS OF PHYSICIAN

ANY CHARGES FOR THE COMPLETION OF THIS FORM OR THE PROVISION OF RELATED DOCUMENTS ARE THE RESPONSIBILITY OF THE CLAIMANT

First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

EMPLOYER'S STATEMENT

(TO BE COMPLETED BY YOUR PRESENT EMPLOYER)

IF SELF-EMPLOYED ALSO COMPLETE PAGE 4a

EMPLOYEE NAME (CLAIMANT)	EMPLOYEE ID NUMBER

NAME OF EMPLOYER (COMPANY NAME)	EMPLOYER ADDRESS CITY PROVINCE POSTAL CODE	EMPLOYER TELEPHONE PHONE ( ) FAX ( )

DATE EMPLOYEE STARTED EMPLOYMENT WITH YOUR COMPANY MONTH DAY YEAR	EMPLOYMENT TYPE ❑ FULL TIME ❑ PART TIME ❑ CASUAL ❑ SEASONAL ❑ APPRENTICE	LAST DATE EMPLOYEE WORKED MONTH DAY YEAR

IF PART TIME OR CASUAL, PLEASE DESCRIBE SCHEDULE AND AVERAGE NUMBER OF HOURS WORKED PER WEEK.	
IF SEASONAL, HOW MANY YEARS HAS THE EMPLOYEE WORKED FOR THIS COMPANY?	IF SEASONAL, PLEASE PROVIDE THE YEARLY WORK SCHEDULE

WHAT IS THIS EMPLOYEE'S OCCUPATION?	PLEASE DESCRIBE THE MAIN DUTIES OF THIS OCCUPATION
DOES YOUR EMPLOYMENT OFFER LIGHT/MODIFIED DUTIES TO EMPLOYEES? ❑ YES ❑ NO	IF SO, PLEASE BRIEFLY OUTLINE:
HAS THIS EMPLOYEE PERFORMED OTHER OCCUPATIONS FOR YOUR COMPANY? ❑ YES ❑ NO	IF SO, PLEASE LIST JOBS PERFORMED, AND THE MAIN DUTIES OF THESE JOBS.

WAS THIS A WORK RELATED INJURY? ❑ YES ❑ NO	IS THERE A WCB CLAIM? ❑ YES ❑ NO PROVIDE CLAIM NUMBER: _____	HAS EMPLOYEE HAD PRIOR TIME OFF FOR THE SAME OR SIMILAR CONDITION? ❑ YES ❑ NO IF SO, WHEN? _____	WAS THE LAST DAY WORKED DUE TO: ❑ TERMINATION ❑ LAYOFF ❑ STRIKE ❑ DISABILITY ❑ QUIT ❑ LOCK-OUT ❑ OTHER, PLEASE SPECIFY: _____

HAS THE EMPLOYEE WORKED ANY DAYS SINCE THE DATE OF THE DISABILITY? ❑ YES ❑ NO	IF YES, PLEASE SPECIFY DATES:	**EMPLOYEES ANTICIPATED DATE OF RETURN TO WORK** LIGHT DUTIES MONTH DAY YEAR NORMAL DUTIES MONTH DAY YEAR

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF YOUR EMPLOYEE GROUP MEDICAL PLAN, INCLUDING ANY I.D. NUMBERS RELATING TO THIS EMPLOYEE:

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DECLARATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

EMPLOYER REPRESENTATIVE SIGNATURE

PRINTED NAME IN FULL

TITLE

DATE

ANY CHARGES FOR THE COMPLETION OF THIS FORM OR THE PROVISION OF RELATED DOCUMENTS ARE THE RESPONSIBILITY OF THE CLAIMANT.

Continued on next page

First Canadian Insurance Corporation

320 SIOUX ROAD
SHERWOOD PARK, ALBERTA
CANADA T8A 3X6
TEL: (780) 467-9575
FAX: (780) 467-4650

EMPLOYMENT INFORMATION AT THE TIME OF POLICY PURCHASE
(complete only if different from present employer)

Please provide a copy of your Record of Employment that was issued by your Previous Employer

NAME OF PREVIOUS EMPLOYER	EMPLOYER ADDRESS	PHONE ( ) FAX ( )
DATE YOU STARTED WITH THIS COMPANY	LAST DATE YOU WORKED MONTH DAY YEAR	
❑ FULL TIME ❑ APPRENTICE ❑ PART TIME ❑ CASUAL ❑ SEASONAL ❑ UNEMPLOYED	OCCUPATION AND DESCRIPTION	

COMPLETE IF YOU ARE SELF-EMPLOYED

PLEASE PROVIDE:

❑ PHOTOCOPY OF YOUR BUSINESS LICENSE

❑ PHOTOCOPY OF YOUR BUSINESS NOTICE OF ASSESSMENT FROM REVENUE CANADA FOR THE FOLLOWING PERIODS:

- THE YEAR YOU PURCHASED YOUR POLICY
- THE MOST RECENT YEAR PRIOR TO YOUR DISABILITY

❑ PLEASE ALSO PROVIDE THE STATEMENT OF BUSINESS OR PROFESSIONAL ACTIVITIES (T2125), OR, IF YOUR BUSINESS REQUIRES AN ALTERNATE STATEMENT (IE. STATEMENT OF FARMING ACTIVITIES (T2042) FOR BOTH RELEVANT PERIODS ABOVE.

ONCE THESE DOCUMENTS HAVE BEEN REVIEWED, WE WILL ADVISE YOU IF FURTHER INFORMATION IS REQUIRED. THIS MAY INCLUDE A REQUEST FOR THE FOLLOWING:

❑ PHOTOCOPIES OF BUSINESS INVOICES FOR THE PERIOD ONE MONTH PRIOR TO THE PURCHASE AND ONE MONTH PRIOR TO THE ONSET OF YOUR DISABILITY.

❑ PHOTOCOPIES OF BUSINESS BANK STATEMENTS FOR THE PERIOD ONE MONTH PRIOR TO THE PURCHASE AND ONE MONTH PRIOR TO THE ONSET OF YOUR DISABILITY.

YOUR CLAIMS EXAMINER CAN DISCUSS THE SPECIFICS OF WHAT IS REQUIRED TO SUPPORT YOUR EMPLOYMENT ELIGIBILITY ONCE YOUR CLAIM FORMS ARE RECEIVED.

NAME OF COMPANY: _____ LEGAL ENTITY NAME: _____ (FOR NUMBERED COMPANIES)

DATE YOUR BUSINESS STARTED: _____ NUMBER OF EMPLOYEES: _____ PERCENTAGE OF OWNERSHIP: _____

PLEASE PROVIDE THE DATE LAST WORKED DUE TO YOUR DISABILITY: _____

ARE YOU CURRENTLY PERFORMING ANY DUTIES OF YOUR OCCUPATION? ❑ YES ❑ NO

IF SO, PLEASE LIST THESE DUTIES AND HOW THEY DIFFER FROM YOUR NORMAL DUTIES:

TYPE OF EMPLOYMENT: ❑ FULL TIME ❑ PART TIME ❑ SEASONAL

IF SEASONAL, PLEASE LIST USUAL MONTHS OF EMPLOYMENT: _____