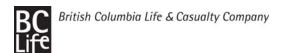
Waiver of Premium Claim Checklist

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1 Telephone 604 419-8040 Fax 604 419-8055

| | your claim quickly and accurately. Ensure that the following forms that the originals of these forms are submitted: |
|-----------------------|--|
| □ W | Vaiver of Premium Claim Form |
| □ Ir | nitial Attending Physician's Statement |
| | Claimant Questionnaire |
| deadline. If you have | enefit must be submitted to BC Life by your policy claiming any questions about your claim or about these forms, please Claims Department at 604 419-8040. |
| Complete and mail y | your claim to: |
| Disab | sh Columbia Life & Casualty Company Dility & Life Claims Box 7000 |

Vancouver BC V6B 4E1

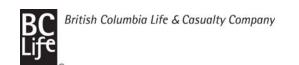


Waiver of Premium **Claim Form**

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4EI Telephone 604 419-8040 Fax 604 419-8055

Employer's Statement

| · • | | | | |
|--|---|--|--|--|
| Name of group policyholder | Policy number | | | |
| Name of employee | Social insurance number | | | |
| Date employed Mo Day Yr | Occupation | | | |
| Date last worked Mo Day Yr | Date returned to work or expected to return to work | | | |
| Effective date of employee's insurance | | | | |
| Basic earnings on last day worked \$p | er Amount of insurance on last day worked \$ | | | |
| Please provide any other information that will help BC L | ife assess this claim | | | |
| I certify that the information provided above is true and c | omplete to the best of my knowledge and belief. | | | |
| Completed by (please print) | Phone number Date Mo Day Yr | | | |
| | Title | | | |
| Employee's Statement (must be complete | ed by employee) | | | |
| Name | Date of birth \[\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | |
| | Box no. if applicable | | | |
| City | Province Postal Code Phone number | | | |
| Are you now medically unable to work? | lo If yes, provide date last able to work | | | |
| Describe the illness or injury that prevents you from wor | rking | | | |
| List all physicians, surgeons and practitioners who have tr | | | | |
| Name Addres | S Dates of attendance Disease or condition | | | |
| | Mo Day Yr | | | |
| | Mo Day Yr | | | |
| | Mo Day Yr | | | |
| Have you been hospitalized for this condition? ☐ Yes | ☐ No If yes, provide hospital information below: | | | |
| Name of hospital | Date admitted Date discharged | | | |
| | | | | |
| What activities can you perform? | Mo Day Yr Mo Day Yr | | | |
| When do you expect to return to work? Please provide a | approximate date | | | |
| I, the undersigned, hereby make claim for the above men needed to establish the validity of this claim to British Col be as valid as the original. I certify that the above answer | tioned benefit. I authorize the release of all reports and medical information which may be umbia Life & Casualty Company (BC Life). I agree that a photocopy of this authorization shall s are true and complete to the best of my knowledge and belief. I understand that my h the Privacy Policy of BC Life in effect from time to time. | | | |
| Signature of employee | Date Mo _Day _ Yr | | | |



Initial Attending Physician's Statement

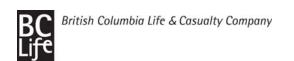
Disability & Life Claims PO Box 7000 Vancouver BC V6B 4EI Telephone 604 419-8040 Fax 604 419-8055

Please assist your patient by providing all details relevant to his/her condition. Cross out those questions that are not applicable.

| ١. | Name of patient: Date of birth |
|----|--|
| 2. | Patient's: Height Weight |
| 3. | Diagnosis: |
| | |
| 4. | Additional conditions or complications: |
| 5. | Does your patient require treatment for substance abuse? |
| 6. | DSM IV (if applicable): GAF score: |
| 7. | Objective findings (please include copies of test results: current X-rays, diagnostic tests, E.K.G.'s, blood pressure readings, etc.): |
| 8. | Subjective complaints (including severity and frequency): |
| 9. | Date symptoms began: Date your patient stopped work due to these symptoms: Mo Day Yr |
| 10 | Has your patient ever had the same or similar condition? Yes No If yes, when, and provide details: |
| | Is this condition caused in any way by the patient's employment? Yes No If yes, have you submitted a WCB claim form? Yes No No Date of first visit: Mo Day Yr |
| | Mo Day Yr Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): |
| 14 | Medications: provide type, start date, dosage and frequency, response and adjustment date if applicable |
| | |

Initial Attending Physician's Statement (page 2)

| I5. Please provide details of other treat | ment (surgery, physiotherapy, psychotherapy, | etc.) including dates, recommended frequency, e | tc |
|--|---|---|---------------|
| 6.ls your patient following the recomi | mended treatment? Yes No If yes, | what has been the response? If no, explain _ | |
| 17. Names, addresses and specialty of oup reports) | other physicians or treatment providers referr | red to: (please include copies of any consultat | ion and follo |
| Name | Address | Specialty | |
| | | | |
| | | Date admitted Date discharged Mo Day Yr Mo | |
| 19.What are your patient's mental and | physical limitations and how do they affect the | e activities of daily living? | |
| 20.Has your patient: ☐ recove | ered 🗖 improved 🗖 not improve | d □ retrogressed | |
| | , do you expect your patient to return to pre- | illness/accident functioning? 🗖 Yes 🔲 No | |
| | | | |
| 23. Do you believe your patient is comp | petent to endorse cheques and direct the use o | of the proceeds? | |
| 24. Please provide any additional inform | nation you believe we should be aware of conc | erning your patient's condition: | |
| | te to the best of my knowledge and belief. | | |
| Name and specialty (please print) | | | |
| Address (please print) | | Phone Number | |
| Signature | | MD | |



Claimant Questionnaire

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4EI Telephone 604 419-8040 Fax 604 419-8055

| | Social insurance number | | | | | |
|--|-------------------------|---------------------|-----------------|-------------------|------------------|-----------|
| ccupational Information | | | | | | |
| our job title | | | | er of years perfo | rming this job | |
| Describe the essential duties of your job | | | | | | |
| s there any specialized equipment you are required to u | se on a daily ba | sis? 🗆 Yes | □ No If yes, | please describe: | | |
| Please indicate the approximate number of hours you ar | e involved in the | e following activit | ies during your | normal work day | ·: | |
| Walking Standing | | Sitting | | Be | nding | |
| Only complete this section if your job involves liftinactivities required in your job. Physical activities required | - , - | d reaching. Plea | | ie applicable sp | aces below, thos | e physica |
| , | Less than I | - | 3-4 | 5-6 | 7-8 | |
| LIFTING under 10 pounds | | | | | | |
| II - 20 pounds | | | | | | |
| 21 - 50 pounds | | | | | | |
| over 50 pounds | | | | | | |
| CARRYING under 10 pounds | | | | | | |
| II - 20 pounds | | | | | | |
| 21 - 50 pounds | | | | | | |
| 2. 55 pounds | | | | | | |
| over 50 pounds | | | | | | |
| | | | | | | |
| over 50 pounds | | | | | | |

| Medical Information | Claimant Questionnaire (page 2 |
|--|--|
| Please describe any limitations and restrictions you have as a result of your medical condition(s). | |
| | |
| | |
| Describe in detail the way in which your symptoms prevent you from performing any or all of the | essential duties of your job. |
| | |
| Education and Employment Background | |
| Highest grade achieved (please circle) I 2 3 4 5 6 7 8 9 | 10 11 12 13 |
| Technical or trade school attended Diploma of | obtained |
| Apprenticeships | |
| College or University: | |
| (a) Name of college or university | |
| (b) Years completed (c) Degree obtained | (d) Major |
| Other (vocational courses, programs, training, certificates, etc. and year completed or obtained) _ | |
| Language(s) spoken fluently | |
| | |
| Please complete the following, providing details on the jobs you have held (last job first). If insuffic | |
| Employer Job title Dates of emplo | oyment Essential job duties performed |
| | |
| | |
| | |
| Skills and Interests | |
| What job skills have you acquired in your current and previous jobs? | |
| | |
| Please describe any community projects or volunteer work that you are or have been involved with | h. |
| | |
| | |
| What are your hobbies or interests ? | |
| | |
| Are there any jobs that you are interested in, such as ones based upon your hobbies/interests, prev | vious work experience, and/or education? |
| | |
| | |
| Do you currently have: a) a valid driver's license? Yes No What class? | |
| c) any driving restrictions as a result of your condition? \Box Yes \Box | No Explain |
| b) a car 🔲 Yes 🔲 No | |
| I certify that the information provided above is true and complete to the best of my knowledge and | d belief. |
| Simple was of all impact | Data I I I I |
| Signature of claimant | Date |