Short-Term Disability Income Benefit

Employee's Statement

Great-West Life

your Benefits Solutions People

THE Great-West Life ASSURANCE COMPANY

Employee's Statement
Short Term Disability Income Benefits

This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within five days of the onset of your disability. Your notice form, and any other correspondence you may wish to provide about your claim, should be submitted to the Great-West Life disability management services office assigned to assess your claim. Should you wish to submit your notice form directly to Great-West Life, please contact your employer for the appropriate mailing address.

1. Notice of Claim

The Notice of Claim asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your **Group Plan Number**.

Note: If you have Guaranteed Standard Issue Program coverage with Great-West Life, this form will be used as Notice of Claim for that coverage as well.

2. Authorization Request

We need your permission to obtain information that will help us assess your claim. By signing this authorization request, you give Great-West Life permission to obtain this information from your doctor, your employer, other insurers and hospitals where you received treatment.

3. Attending Physician's Report

Ask your doctor to complete this form. It requests general information about your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance coverage began, your job duties and earnings. We have asked your employer to supply this information directly to us.

Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

THE Great-West Life ASSURANCE COMPANY

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   P.O. Box _____

   City _____ Province _____ Postal Code _____

   Telephone: Home (_____) _____ Work (_____) _____

2. Your GWL Employee Identification Number _____

   Your Identification number must be completed. If unknown, please check with your employer.

3. Social Insurance Number _____

   If your employer pays for all or any part of your disability benefits coverage, any benefits payable may be subject to income tax. If this applies to you, please provide your Social Insurance Number for income tax reporting purposes. Your Social Insurance Number may also be used as an identification number where required in the administration of benefits.

4. Date of birth: Year _____ Month _____ Day _____

Employer Information

1. Your Employer's Name: _____

   Address: Street & Number _____

   City _____ Province _____ Postal Code _____

   Telephone Number: (_____) _____

2. Group Plan Number _____

   Plan number must be completed. If unknown, please check with your employer.

Claim Information

1. What is the nature of your condition? _____
2. If disability is due to an accident, give date accident occurred: Year _____ Month _____ Day _____

   Where and how did it occur? _____

   Was the accident work-related? ☐ Yes ☐ No
3. From what date has your disability continuously prevented you from performing your regular work?

   Year _____ Month _____ Day _____
4. Have you performed any **other** work since that date? ☐ Yes ☐ No

   If yes, describe _____
5. Are you able to do any other work? ☐ Yes ☐ No

   If yes, describe _____
6. Please provide the name(s) and telephone number(s) of your attending physician(s).

   _____

Financial

1. Have you applied for, or are you receiving the following:

	I have Applied		I am Receiving		
	Yes	No	Yes	No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☐	☐	☐	$ _____
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ _____
Employment Insurance Benefits	☐	☐	☐	☐	$ _____
Automobile Insurance Benefits	☐	☐	☐	☐	$ _____
Any other Disability Benefits	☐	☐	☐	☐	$ _____
Employer Sponsored Retirement / Pension Plan Income	☐	☐	☐	☐	$ _____
Self Employment Income or any other Employment Income			☐	☐	$ _____
Any other income	☐	☐	☐	☐	$ _____

For the duration of your claim for benefits, it is your responsibility to notify Great-West Life of:

- any work performed, whether or not you have received a wage or remuneration, or
- any employment income paid to you or any other person or party as a result of work performed by you.

2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes _____ Plan Number ☐ No

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

Date: _____ Signature: _____

DIRECT DEPOSIT AUTHORIZATION

You can have your benefit payments automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life. **All benefit payments covered under one plan number will be deposited into the same bank account**.

If you'd like to take advantage of Electronic Funds Transfer, please fill in the information below.

Effective _____ (date) please deposit my payments to the following account

☐ Savings Account, (please consult your bank for proper bank identification number.)

☐ Chequing Account, (please attach sample cheque marked "VOID")

PLEASE PRINT

NAME OF BANK, TRUST CO., CREDIT UNION, ETC.	TRANSIT NO. INSTITUTION NO. ACCOUNT NO.
BRANCH ADDRESS	NAME IN WHICH ACCOUNT IS HELD
CITY OR TOWN & PROVINCE POSTAL CODE	

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

SIGNATURE OF EMPLOYEE _____ DATE _____

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Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

Print Name _____ Signature _____

Date _____ Telephone Number _____

THE Great-West Life ASSURANCE COMPANY

INITIAL ATTENDING PHYSICIAN'S STATEMENT
SHORT TERM DISABILITY INCOME BENEFITS

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of Patient: _____ Employee Identification # _____

Name of Employer: _____ Plan Number _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Date: _____ Signature of Patient: _____

1. **History**

   Date symptoms first appeared or accident happened. Year _____ Month _____ Day _____

   Has patient ever had the same or similar condition? ☐ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment _____

   _____

2. **Diagnosis** (including any complications)

   Primary _____

   Secondary _____

   Subjective Symptoms: _____

   Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

   _____

   _____

3. Current Height _____ Current Weight _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year _____ Month _____ Day _____

5. **Treatment**

   What is the current treatment regimen? (drug dosage, physio, other and progress)

   _____

   _____

   _____

   Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

6. If condition is due to pregnancy, what is (or was) the expected date of confinement?

   Year _____ Month _____ Day _____

7. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No
   If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

8. Please indicate your patient's current physical abilities:

   ☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

   ☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

   ☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

   ☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

   List physical restrictions and tolerances: _____

   In your opinion, what is the earliest date your patient will be able to return to work?

   Year _____ Month _____ Day _____

   If the previous job could be modified, when could rehabilitation employment commence?

   Year _____ Month _____ Day _____

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

   _____

   _____

10. **Hospitalization** if applicable for this illness or injury

    Date of in-patient admission: Year _____ Month _____ Day _____

    Date of discharge: Year _____ Month _____ Day _____

    Date of out-patient treatment: Year _____ Month _____ Day _____

    Name of hospital: _____

11. **Surgery**

    Surgical procedure performed: _____

    Date of surgery: Year _____ Month _____ Day _____

    Name of surgeon: _____

12. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

    _____

    _____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____

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