

Great-West

G R O U P

Short Term Disability Income Benefits
Employee's Statement

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 Policy Number**.

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.

NOTICE OF CLAIM

Identification

- Mr. Mrs. Ms.
Name: First _____ Initial _____ Last _____
Address: Street & Number _____
 P.O. Box _____
 City _____ Province _____ Postal Code _____
2. Telephone: Home (_____) _____ Work (_____) _____
Your GWL Employee Identification Number _____
Your Identification number must be completed. If unknown, please check with your employer.
3. Social Insurance Number _____
I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number when required in administering my benefits.
Employee's Signature _____
4. Date of Birth: Year _____ Month _____ Day _____

Employer Information

1. Your Employer's Name: _____
Address: Street & Number _____
 City _____ Province _____ Postal Code _____
2. Group Policy Number _____
Policy 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		Amount
	Yes	No	Yes	No	
Canada Pension Plan/Quebec Pension Plan Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Workers' Compensation Board Benefits (or similar plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employment Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Automobile Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Sponsored Retirement / Pension Plan Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Self Employment Income or any other Employment Income			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

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
- 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 or Life Insurance Coverage with Great-West Life?

Yes No If so, please provide your policy number: _____

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 disability benefit payment cheques automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life.

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

Effective _____ (date) please deposit my disability 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.	BANK NO.	TRANSIT NO.	ACCOUNT NO.
BRANCH ADDRESS		NAME IN WHICH ACCOUNT IS HELD	
CITY OR TOWN & PROVINCE	POSTAL CODE		

Signature of Claimant

Date

Note: For Institutions Within Canada Only

Protecting Your Personal Information

At Great-West, we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your files to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to investigate and assess your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- Great-West, any healthcare provider, my plan administrator, other insurance companies, administrators of government benefits, other organizations, or benefit service providers working with Great-West to exchange personal information, when necessary to investigate and assess my claim and to administer the group benefit plan;
- Great-West to exchange personal information with my employer, plan sponsor, or plan administrator for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West to release any personal information about my claim for audit purposes to my employer or plan sponsor or their agent, if such an audit is approved by Great-West, to ensure the efficient assessment of the claims.

This authorization 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 Employee's Statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of this claim.

 Print Name

 Signature

 Date

 Telephone Number

**ATTENDING PHYSICIAN'S INITIAL STATEMENT
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: _____ GWL Employee Identification _____

Name of Employer: _____ Plan Number _____

I hereby authorize the release of any information requested on this form to The Great-West Life Assurance Company or any of its agents.

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 of up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing or 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 _____