canada life

Disability Income Benefits
Employee Statement

To begin the claim submission process, you must complete the Employee Statement and the consent form. Please have your doctor complete a physician's statement. These forms should be submitted within ten days of the onset of your disability or, if applying for Long Term Disability or a Life Waiver of Premium benefit, no later than eight weeks before the end of the waiting period. **Benefits may be denied if these forms are submitted later than the notice period in your group contract.**

NOTE: Canada Life takes the submission of fraudulent claims seriously and will verify the accuracy of the information given in support of your claim.

☐ **I certify that the information given on this claim form is true, correct, and complete to the best of my knowledge.**

Your Employer's Name: REFRIGERATION WORKERS H & W PLAN

Your Plan Number: 44541 Your Canada Life ID Number: _____

YOUR INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of Birth: _____ Social Insurance Number: _____

Your Social Insurance Number is required as your disability benefit may be subject to income tax deductions.

Home Address: _____

City / Town: _____ Province / Territory: _____ Postal Code: _____

Is your mailing address the same as above? ☐ Yes ☐ No If no, please provide mailing address.

Mailing Address: _____

City / Town: _____ Province / Territory: _____ Postal Code: _____

Location where you work: City / Town: _____ Province / Territory: _____

Home Phone: _____ ☐ Confidential

Cell Phone: _____ ☐ Confidential

Work Phone: _____ Ext: _____ ☐ Confidential

Check the Confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Email Address: _____

Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim.

CLAIM INFORMATION

Your last day of work: _____ (mm/dd/yy) Your first day unable to work: _____ (mm/dd/yy)

During your absence, have you performed any other work? ☐ No ☐ Yes Describe:

Have you returned to work?

☐ Yes When did you return to work? _____ (mm/dd/yy)

Have you returned to (select all that apply): ☐ Regular duties and hours ☐ Modified duties ☐ Modified hours

☐ No When do you expect to return to work: _____ (mm/dd/yy) **OR** ☐ Unknown **OR** ☐ I'm not planning to return

What is the nature of the medical condition that is/was preventing you from working?

Is your condition work related? ☐ No ☐ Yes

Your consent

Before we can process your claim for benefits, you must read this agreement and sign in the *signature* box below.

Sharing your personal information

We collect, use and disclose your personal information to:

- investigate and assess your claim
- administer your claim and the group benefits plan
- work out a rehabilitation plan to get you back to work
- audit the assessment of the claim.
- manage internal data for analytics purposes

We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Insurance and reinsurance companies
- Administrators of the plan, of government benefits and of other benefit programs
- Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
- Your employer's occupational health services
- Your union representative
- Service providers and other organizations working with us, or on behalf of the other parties mentioned above. We may use service providers outside Canada.
- An auditor authorized by us, your employer, plan sponsor or their agent

Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only persons with access to the information are:

- people working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim
- those whom you've given access
- those authorized by law both within Canada and in any other jurisdiction where your personal information is held.

For a copy of our Privacy Guidelines see **canadalife.com** or you can write to Canada Life's Chief Compliance Officer.

By signing below, you confirm that:

- You have read, understand and agree with the contents of this form and authorize us to collect and disclose your personal information.
- Except for audit purposes, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete
- A photocopy or electronic copy of this authorization is as valid as the original.

Your group plan number 44541	Print your name	Telephone number
Your Canada Life ID number	Email Address	*Enter your email address if you would like Canada Life to communicate with you by secure email about your Disability Services claim.*
Your signature X		Date (mm/dd/yyyy)

CLAIM INFORMATION (con't)

Is your condition the result of an accident? ☐ No ☐ Yes If yes, answer the following questions:

When did the accident occur? _____ (mm/dd/yy)

Provide details of the accident _____

Was the accident a motor vehicle accident? ☐ No ☐ Yes In what province did your accident occur? _____

Were you admitted to a hospital? ☐ No ☐ Yes Hospital Name: _____

Date admitted: _____ (mm/dd/yy) Date discharged: _____ (mm/dd/yy) **OR** ☐ Still hospitalized

Have you had surgery since being off work, or is surgery planned? ☐ No ☐ Yes

Date of surgery: _____ Type of surgery: _____

Is recovery from your surgery the only medical condition keeping you from working? ☐ No ☐ Yes ☐ Unknown

Please provide the following information of your health care provider related to this claim:

Primary Physician: _____ Specialty: _____

Address: _____ Phone Number: _____

Do you have other health care providers related to this claim? ☐ No ☐ Yes If yes, provide details.

Provider Name: _____ Specialty: _____

Address: Phone Number: _____

Provider Name: _____ Specialty: _____

Address: _____ Phone Number: _____

INCOME DECLARATION AND REIMBURSEMENT AGREEMENT

I understand that:

- I am required to apply for disability benefits that I or another member of my family might become entitled to receive because of my disability, and that I may be asked by Canada Life to reapply or appeal decisions refusing my application(s) where considered appropriate.
- during the time it takes for my application for these other disability benefits to be accepted, or my entitlement to any other reportable income to be reviewed, Canada Life will continue paying me amounts equivalent to the disability benefit payments I am eligible to receive under the Group Plan, provided I continue to be eligible for these disability benefit payments under the Group Plan (the "Advance"). The terms "other disability benefits" and "other reportable income" refer to any of the types of disability benefits and other income mentioned under the Offset, All Source Maximum, Coordination of Benefits and Subrogation and Right of Recovery provisions under the Group Plan, as well as any other amounts, including damages for loss of income, that I may receive or become entitled to receive as a result of my disability.
- if I am entitled to receive disability benefits or any other reportable income, this may result in an overpayment ("Overpayment") that I will be required to pay back to Canada Life. I specifically give up my rights under any law that qualifies the Advance, the Overpayment, the other disability benefits, or any other reportable income, as property exempt from seizure.
- Canada Life may reduce my disability benefit payments by the amount of other disability benefits or other reportable income that I receive or become entitled to.

I agree to:

- notify Canada Life within 15 days of receipt of other disability benefit payments or any other reportable income.
- repay Canada Life within the time frame Canada Life advises me of after I am notified of the Overpayment amount or within a longer period if Canada agrees in writing. I understand that if the Overpayment is not repaid when due, Canada Life may take all necessary steps to recover the Overpayment, including withholding the payment of, or recovering the Overpayment from, any benefits payable under the Group Plan.

FINANCIAL INFORMATION

Have you applied for, or are you receiving any income either as a result of your disability or otherwise (please check no or yes)?

- Canada Pension Plan/Quebec Pension Plan or Worker's Compensation Board Benefits (or similar benefits). ☐ No ☐ Yes
- Any other income? Examples: automobile accident benefits, employer sponsored STD or sick leave benefits, Employment Insurance benefits, retirement or pension plan income. ☐ No ☐ Yes.

  If you answered yes, attach a copy of the initial benefits statement for each type of other income.
- Self employment or other employment income. ☐ No ☐ Yes.

  If you answered yes, attach a copy of your pay/salary details.

All of the income described above is referred to as "reportable income".

If you have any of the following coverage with Canada Life or London Life, please select all that apply:

☐ Individual Disability Insurance Plan# _____

☐ Individual Life Insurance Plan# _____

☐ Creditor/Loan Insurance Plan# _____

☐ Critical Illness Insurance Plan# _____

☐ Guaranteed Standard Issue

Note: *If you have Guaranteed Standard Issue coverage with Canada Life this form will be used as notice of claim for that coverage as well.*

DIRECT DEPOSIT

! Provide your banking information or attach a void cheque where you want your disability benefits to be deposited to. If space is left blank, previously provided banking information for other benefits under this group plan (i.e. Healthcare or Dentalcare) will be used for any disability income benefits payable.

Name of bank/credit union: _____

Transit number: ☐☐☐☐☐ Institution number: ☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐☐☐☐

DECLARATION

☐ I declare the information I've entered is accurate. I understand and agree to the terms in the Income Declaration and Reimbursement Agreement section. I also acknowledge that I need to print, sign, and submit my Consent Form to Canada Life.

Signature: _____ Today's date: _____

canada life™

The patient is responsible for any fees related to the completion of this form.

CLHIA ACCAP

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	Canada Life Employee Identification Number
REFRIGERATION WORKERS H&W PLAN	44541	

Height	Weight	Date of Birth (dd/mm/yyyy)

Last Date Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life for the purposes stated above. I acknowledge that my consent enables Canada 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.

_____ _____

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

TO BE COMPLETED BY THE PHYSICIAN (or Nurse Practitioner Where Applicable)

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: _____

Secondary and/or Complications: _____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐	Auto Accident Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy)	If yes, date of event: (dd/mm/yyyy)
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): _____ Date of discharge (dd/mm/yyyy): _____ Institution Name: _____

If surgery was performed please provide date and description of surgery:

Date (dd/mm/yyyy): _____ Description: _____

Treatment (drug, dosage, physiotherapy, other):

Prognosis Please provide the prognosis for recovery:

canada life™

CLHIA ACCAP

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date (dd/mm/yyyy): _____ Treatment Provider: _____

Please describe the patient's symptoms including history, severity and frequency:

_____

_____

_____

_____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**
- **do not provide genetic test results**

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

Name of Specialist: _____ Specialty: _____ Date of Visit: _____

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities.

_____

_____

_____

_____

_____

_____

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

_____

_____

_____

_____

_____

_____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

_____

_____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	