

### 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 HOLD PLAN 44541 Your Plan Number: Your Canada Life ID Number: Middle Initial:\_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other Your Social Insurance Number is required as your disability benefit may be subject to income tax deductions. Social Insurance Number: Home Address: Province / Territory: \_\_\_\_\_ Postal Code: Is your mailing address the same as above?  $\square$  Yes  $\square$  No  $\square$  If no, please provide mailing address. Mailing Address: \_\_\_\_\_ Province / Territory: \_\_\_ Postal Code: \_\_\_\_\_ City / Town: \_\_\_\_ Location where you work: City / Town; Province / Territory: Home Phone: \_\_\_\_\_ 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 \_\_\_\_ Confidential Cell Phone: message with callback information at that number. Work Phone: \_\_\_\_\_ Ext: Confidential Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim. Email Address: 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):  $\square$  Regular duties and hours  $\square$  Modified duties  $\square$  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? \( \subseteq \text{No} \subseteq \text{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

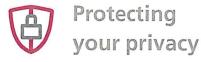
We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

### 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

## 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.



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.

- 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 XX		Date (mm/dd/yyyy)	



CLAIM INFORMATION (con't)						
Is your condition the result of an accident?   No  Yes If yes, answer the following questions:						
/hen 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?						
Date admitted: (mm/dd/yy) Date discharged: (mm/dd/yy	v) OR Still hospitalized					
Have you had surgery since being off work, or is surgery planned?						
Date of surgery: Type of surgery:						
Is recovery from your surgery the only medical condition keeping you from working?						
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? $\square$ No $\square$ Yes $\square$ If yes, provide details.						
Provider Name:	Specialty:					
Address:	Phone Number:					
Provider Name:	. Specialty:					
Address:	Phone Number:					

#### INCOME DECLARATION AND REIMBURSEMENT AGREEMENT

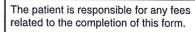
#### I understand that:

- 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).   \[ \sum_{No} \sum_{Yes} \]				
	20 E NOME C			
the second secon	omobile accident benefits, employer sponsored STD or sick leave benefits, Employment Insurance benefits, retirement			
or pension plan income.  No				
	of the initial benefits statement for each type of other income.			
Self employment or other employr				
If you answered yes, attach a cop	y of your pay/salary details.			
All of the income described above is re	ferred to as "reportable income".			
If you have any of the following coverage	ge 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 Issu	e 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:			
ii*00(	Dia 1:07:00 P 7:00 P 7:00 D P			
STORT THE COLUMN				
	TRANSIT# INSTITUTION# ACCOUNT#			
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:			







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

Plan Member/Employ	ee Information and Consent:	TO BE CO	MPLETED BY	THE PATIE	NT	
Plan Member/Employee Nan	THE PARTY OF THE P		Home Phone # (+		Cell Phone # (+ Area Code)	
Address (Street, City, Province,	Postal Code)			***************************************		
Employer's Name REFRIGERATION WORKERS HIW PLAN		Group Plan Number Ca		Canada Life	Canada Life Employee Identification Number	
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)				
consultation reports, to Cana Life and administering the gr I acknowledge that the personanda Life to process my of This consent may be revoked	rehabilitation provider to disclose my da Life for the purpose of investigating oup benefits plan. <b>Medical and health</b> sonal information is needed by Canacelaim(s) and refusing to consent may red by me at any time by sending a writter electronic copy of this authorization shadows.	personal informand assessing information eda Life for the sult in delay or en instruction.	mation, including r my claim(s), admin xcludes genetic t purposes stated a denial of my claim	istering covera <b>est results.</b> above. I ackno	ge(s) that I may have with Canada	
Plan Member/Employee Sigr	nature	Date of Con	sent (dd/mm/yyyy)			
TO BE COMPLETED I	BY THE PHYSICIAN (or Nurse		, ,,,,,	icable)		
Primary Diagnosis:	PLEASE COMPLETE TO	O THE BEST C	F YOUR KNOWLI	EDGE		
Secondary and/or Complicat						
If Childbirth - Expected or Ac	tual Delivery Date (dd/mm/yyyy)		\	/aginal 🗌 C-S	ection	
Occupational Illness/injury Yes  No		Auto Accident Yes No No				
If yes, date of event: (dd/mm/			of event: (dd/mm/yyy			
Date of first visit to you perta (dd/mm/yyyy)	ining to this condition:	(dd/mm/yyyy)	work absence due	to condition:		
Hospitalization  Is/was patient hospitalized □ or had day surgery □  Date of admittance (dd/mm/yyyy):  Date of discharge (dd/mm/yyyy):  Institution Name:						
	ase provide date and description of sur	•				
Treatment (drug, dosage, pi	nysiotherapy, other):					
Prognosis Please provide th	e prognosis for recovery:					





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	ur condition in the past? Yes \( \text{No} \( \text{No} \)				
If yes, date (dd/mm/yyyy):	Treatment Provider:				
Please describe the patient's symptoms including h	istory, severity and frequency:				
Frequency of Visits:	☐ Other				
Please attach copies of all relevant:  test results/investigations (If test re consultation reports do not provide genetic test results	sults are not attached, we will interpret this	as tests were not performed)			
If consultation report is not attached, please inc	licate 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 condition	ons 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 recove	ry: (if not completed on page 1)				
Notice to Physician					
The information in this statement will be kept in a lift by the patient or third parties to whom access has be release of any information contained herein.	e, health, or disability benefits file with the insur- een granted or those authorized by law. By pro	er or plan administrator and might be accessible viding the information I consent to such unedited			
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)				