Great-West GROUP

Long Term Disability Income Benefits

Employee's Statement

THE Great-West Life ASSURANCE COMPANY

Employee's Statement
Long Term Disability

This guide explains how to apply for Long Term Disability benefits. It contains the form you must complete to notify Great-West Life of your claim, and explains what will happen after you have submitted that notice.

Your employer will tell you which Great-West Life Disability Management Services Office has been assigned to assess your claim. Your notice form, and any other correspondence about your claim, should be submitted to your employer or to that office.

If you have any questions about your claim, a representative in your Disability Management Services Office will be happy to answer them.

Notice of Claim, Authorization and Physician's Statement

To begin the claim submission process, you should complete the notice of claim and authorization form included in this guide. In addition, please have your doctor complete the brief physician's statement. These forms should be submitted **at least 8 weeks** before the end of the Elimination Period. **Benefits may be delayed if these forms are submitted later than this.**

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.

Claim Interview

To begin the detailed assessment process, a Great-West Life representative may telephone you to obtain information about your job, education and employment history, medical history, and current disability. Information may be required about certain other sources of income that could affect the amount of your benefit.

If an interview is not possible because of medical or language problems, alternative arrangements will be made. If sufficient information is obtained through the claim forms, an interview may not be necessary.

Income Declaration

You will be sent a form asking you to sign a declaration concerning other income to which you may be entitled.

Once you have signed the income declaration, please return the form to Great-West Life. This completes your part in submitting your claim.

Employer's Statement

When your employer gives you this brochure, he/she will submit an employer's statement to Great-West Life. This statement confirms your effective date of insurance coverage, job information, monthly earnings, and other information that is needed to assess your claim.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits, and this includes responsibility for providing medical reports. However, to simplify the application process for you and prevent delays, Great-West Life will request additional medical information directly from your Physician, if required. This also helps to ensure that the questions your Physician is asked are relevant to your claim.

If additional medical information is required, Great-West Life will make every effort to obtain it as quickly as possible. You will be notified if no response has been received within 4 weeks of our request to your physician.

Your physician may or may not request a fee for completing claim reports (including the attached statement). If they do, you are responsible for paying it. Whenever Great-West Life requests information directly from your doctor, a correspondence fee will be offered.

Claim Assessment

Once the employer's statement, your signed Income Declaration form, and medical records have been received, your claim will be promptly and thoroughly assessed by a Case Manager and, if necessary, by a Great-West Life Medical Consultant.

Benefit Approval

If your claim is accepted according to the terms of your group disability plan, Great-West Life will send you a summary of both the benefits that have been approved and any additional benefits that may be available to you. Any limitations which may apply to your claim will also be explained.

Your benefit cheque will be issued on the later of:

1. the date which is one month after your waiting period ends; and

2. the date on which the initial claim assessment is completed.

DIRECT DEPOSIT AUTHORIZATION

Should your claim be accepted, you can have your 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.

☐ Savings Account only, (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	

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

SIGNATURE OF CLAIMANT _____ DATE _____

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 _____

   I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number only where required in the administration of 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 _____

   Telephone Number: (_____) _____

2. Group Policy Number _____

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

Interview Arrangements

1. Please indicate if there are any times or dates when a telephone interview about your claim would be most convenient for you. (Please note that it may be determined that a telephone interview is not required.)

   _____

2. If a telephone interview is not possible, please explain why.

   _____

3. In which official language do you wish us to communicate with you? ☐ English ☐ French

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. Have you had this condition before? ☐ Yes ☐ No

If yes, please elaborate _____

Medical Treatment

1. Name and address of the Physician currently supervising your treatment.

Name: _____ Address: _____

_____

2. Names and addresses of other physicians who have treated you for this condition.

Name: _____ Address: _____

_____

Dates: From _____ To _____

Name: _____ Address: _____

_____

Dates: From _____ To _____

3. Were you confined to hospital? _____ If yes, complete the following:

Hospital Name: _____ Address: _____

_____

Dates: From _____ To _____

Hospital Name: _____ Address: _____

_____

Dates: From _____ To _____

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	☐	☐	☐	☐	$ _____ per month
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ _____ per week
Employment Insurance Benefits	☐	☐	☐	☐	$ _____ per week
Automobile Insurance Benefits	☐	☐	☐	☐	$ _____ per week/month
Any other Disability Benefits	☐	☐	☐	☐	$ _____ per week/month
Employer Sponsored Retirement/Pension Income	☐	☐	☐	☐	$ _____ per week/month
Self Employment or any other Employment Income			☐	☐	$ _____ per week/month
Any other Income	☐	☐	☐	☐	$ _____ per week/month

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 or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes ☐ No If so, please provide your policy number: _____

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

Date: _____ Signature: _____

Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), 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 Life or in the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. We limit access to information in your files 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. We use the information to investigate and assess your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments;
- Great-West Life to exchange my information with my employer, plan sponsor, or plan administrator when relevant for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims.

Except for audit purposes, 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 a claim.

Print Name _____ Signature _____

Date _____ Telephone Number _____

THE Great-West Life ASSURANCE COMPANY

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

Name of Employer: _____ Policy 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 relating 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**

   Date of first visit: Year _____ Month _____ Day _____

   Date of latest visit: Year _____ Month _____ Day _____

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

   If other, please specify _____

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

   _____

   _____

   _____

   _____

6. 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

7. 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 _____

8. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

_____

_____

9. **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: _____

10. **Surgery**

Surgical procedure performed: _____

Date of surgery: Year _____ Month _____ Day _____

Name of surgeon: _____

11. 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 _____

THE Great-West Life ASSURANCE COMPANY

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