THE Great-West Life ASSURANCE COMPANY

Application for Group Short Term Disability Benefits - Employer's Statement

Great-West Life your Benefits Solutions People

Important:
The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed and submitted to Great-West Life within 5 days of the onset of the disability.** Great-West's Privacy Guidelines and applicable law allow claimants to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the claimant.

A. EMPLOYER IDENTIFICATION

Name		Group Policy Number	Division Number (if applicable)	Class (if applicable)
Address: Street & Number	P.O. Box	City	Province	Postal code
Telephone Number		Fax Number		

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	GWL Employee I.D. Number	Social Insurance Number	Date of Birth
Address: Street & Number		P.O. Box	City	Province	Postal Code

C. EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY)

Last day employee was at work (MM/DD/YY)

Employment Class: Is the Employee:

☐ Full time: Number of hours worked per week ____ ☐ Part time: Number of hours worked per week ____

☐ Temporary ☐ Seasonal ☐ Permanent ☐ Contract

☐ Hourly ☐ Salaried ☐ Commissioned

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Temporary Lay-off

☐ Quit ☐ Retired ☐ Other ☐ Work related accident or sickness

Please attach copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work? ☐ Yes ☐ No	If yes, please indicate date returned (MM/DD/YY)	If no, is a return to work date known?
If yes, please indicate expected date of return (MM/DD/YY)	Has employment terminated? ☐ Yes ☐ No	If yes, date (MM/DD/YY)

D. INSURANCE INFORMATION

Original effective date of the employee's Short Term Disability coverage (MM/DD/YY)	Was the employee a late applicant? ☐ Yes ☐ No

E. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

Employee's basic pre-disability weekly earnings (as defined in the contract):	Average monthly commissions earned in the 24 months ending on the last day worked:	Employee benefit amount (according to your records)	TD-1 Claim Code based on personal tax credits:	For Quebec residents, tax deductions according to the latest MR 19:

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ Date: _____

Name (please print): _____ Title: _____

Phone: _____ Fax: _____

F. JOB INFORMATION

Employee's job title as of last day worked	How long has the employee worked in this position? Years Months

COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER. If you have a prepared job description, please include it with this submission.

What are the duties in this job, and what percentage of time does each take per week?

Duties	Percentage of time per week

To ensure proper management of this claim, more detailed job information may be requested at a later date.

When did the employee's disability first appear to affect his/her work? (MM/DD/YY)	In what ways did performance on the job change as a result of the disability?

Were any changes made in the employee's job duties as a result of the disability? ☐ Yes ☐ No

If yes, please explain what the changes were and when they were made:

If the employee could return to part-time or less demanding work, would such work be available? ☐ Yes ☐ No

If no, please explain.

ADDITIONAL INFORMATION

Please provide any additional information that you believe should be considered in assessing this employee's claim.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ Date: _____

Name (please print): _____ Title: _____

Phone: _____ Fax: _____

CLEAR