canada life™

Waiver of Life Insurance Premiums
Employee Statement

To begin your claim submission:
- Complete the Employee Statement and consent form
- Have your healthcare provider complete a physican's statement
- Submit forms within 8 weeks of the end of waiting period. Your claim may be declined if not submitted within 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 the information given on this claim form is true, correct, and complete to the best of my knowledge.**

Your employer's name: ____________________

Your group plan number: ____________________ Your Canada Life ID number: ____________________

Your personal information

First name: ____________________ Middle initial: ______ Last name: ____________________

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of birth: ____________________

Home address: ____________________

City / Town: ____________________ Province / Territory: ____________ Postal Code: ____________

Work location (City / Town and Province / Territory}: ____________________

Home phone : ____________________ ☐ Confidential

Cell 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 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.

What level of education have you completed High School ☐ No ☐ Yes Grade Completed ____________

Business or Trade School ☐ No ☐ Yes College ☐ No ☐ Yes University ☐ No ☐ Yes Years completed ____________

Major/Minor ____________________ Degree/Diploma/Certificate ____________________

Your employment information

What was your last day of work (mm/dd/yyyy): ____________________

What was the first day you were unable to work (mm/dd/yyyy): ____________________

Have you returned to work? ☐ No ☐ Yes **If yes,** when did you return? (mm/dd/yy): ____________________

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

If no, when do you expect to return? (mm/dd/yyyy): ____________________

OR ☐ Unknown **OR** ☐ I'm not planning to return

What aspects of your job are you able to do?

____

____

During your absence, have you performed any **other** work? ☐ No ☐ Yes. If yes, describe:

____

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Your medical information

What is/was the medical condition causing your absence from work?

____

Is your condition work related? ☐ No ☐ Yes. If yes, Worker's Compensation case number: ____________

Is your condition the result of an accident? ☐ No ☐ Yes **If yes:**

When and where did the accident occur? (mm/dd/yyyy): ____________

Provide details of the accident:

____

____

Was the accident motor vehicle related? ☐ No ☐ Yes. **If yes,** in what province did your accident occur? ____________

Your treatment information

Were you admitted to a hospital? ☐ No ☐ Yes Hospital name: ____________

Date admitted (mm/dd/yyyy): ____________ Date discharged (mm/dd/yyyy): ____________ **OR** ☐ Still hospitalized

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

Date of surgery (mm/dd/yyyy): ____________ Type of surgery: ____________

Other treatment (crutches, physiotherapy, medication, etc.):

____

____

____

Please provide the following information for your primary healthcare provider:

Provider's name: ____________ Specialty: ____________

Address: ____________

Phone number: ____________ When did you begin seeing this provider? (mm/yyyy) ____________

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

Provider's name: ____________ Specialty: ____________

Address: ____________

Phone number: ____________ When did you begin seeing this provider? (mm/yyyy) ____________

Provider's name: ____________ Specialty: ____________

Address: ____________

Phone number: ____________ When did you begin seeing this provider? (mm/yyyy) ____________

Please attach a separate sheet if additional space is required

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Your financial information

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

	Applied for	Receiving	Gross Amount	Start Date
• Canada Pension Plan/Quebec Pension Plan:				
o Disability Benefits	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
o Dependent Benefits due to your disability	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
o Retirement Pension	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
o Other (please specify) ____________	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
• Worker's Compensation Board (or similar benefits)	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
• Other income (such as Auto Insurance benefits, Employment Insurance, Pension Plan)	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
Please specify ____________	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________
• Self-employment or other employment income.	☐ No ☐ Yes	☐ No ☐ Yes	____________	____________

Other coverage

Other than the benefits you are applying for here, please indicate if you have other insurance coverage with Canada Life or another insurance carrier:

	Plan/Policy #	Insurance Company
☐ Group Disability Insurance:	____________	____________
☐ Individual Disability Insurance:	____________	____________
☐ Individual Life Insurance	____________	____________
☐ Creditor / Loan Insurance	____________	____________
☐ Critical Illness Insurance	____________	____________

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.

Your group plan number	Your Canada Life ID number	Date (mm/dd/yyyy)

Your name (please print)	Signature
	X

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