

# Disability Income Benefits Employee Statement Guide

## How to apply for disability benefits

Notify Canada Life of your disability as soon as possible:

- Complete the attached Employee statement and consent form
- Mail, fax or email your completed Employee statement, consent form and any other information you'd like us to have, to the Canada Life Disability Management Services Office (DMSO). Fax and email information is available on our website at [canadalife.com](http://canadalife.com), from your employer, or you can contact us at **1-855-755-6729** for assistance.

Your signature on the claim form and the consent is needed to make sure you understand the purpose and benefits of your claim and provides Canada Life permission to get additional information from:

- Your employer
- Other insurers
- Your doctor and other healthcare providers

Send these forms to Canada Life 8 weeks before the end of the waiting period if applying for long term disability, or within 10 days of the disability date if applying for short term disability, to make sure your claim is handled as soon as possible.

## Why we need medical information

Medical information is needed to understand how your condition(s) prevent you from working. Please print the Attending Physician's Statement which best suits your condition(s) and have your healthcare provider complete the form. The completed form can be sent to us directly.

## Information from your employer

Your employer will complete an Employer Statement confirming your employment details and job information to help us assess and administer your disability claim. Your employer will send the completed form to Canada Life directly.

## Your responsibilities

Remember to:

- Keep in touch with your employer, co-workers and Canada Life during your recovery.
- Set goals to help work towards recovery.
- Stay active. Look after yourself.

Talk to your healthcare providers about return-to-work planning. Recovering while at work can be a healthy option. Canada Life supports early return to work opportunities and will work with you to help plan for a healthy future.

To begin your claim submission:

- Complete the Employee Statement and consent form
- Have your healthcare provider complete a physician's statement
- Submit forms 8 weeks before the end of the waiting period if applying for long term disability, or within 10 days of the disability date if applying for short term disability or early referral services. Benefits may be delayed if your claim is received late, or may be denied if the claim is 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 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: \_\_\_\_\_

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: \_\_\_\_\_

Work location (City / Town and 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 message with callback information at that number.*

Cell Phone: \_\_\_\_\_  Confidential

Email Address: \_\_\_\_\_

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

## 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:

\_\_\_\_\_  
\_\_\_\_\_

## Your medical information

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

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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:

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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.):

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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**

## Direct deposit

Provide your banking information below or attach a void cheque if you would like your disability benefits to be deposited directly into your bank account.

If this 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:



## Your financial information

Any income you receive must be reported to Canada Life. 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Dependent Benefits due to your disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Retirement Pension	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Other (please specify) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
• Worker's Compensation Board (or similar benefits)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
• STD or sick leave benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
• Other income (such as Auto Insurance benefits, Employment Insurance, Pension Plan)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Please specify _____				
• Self-employment or other employment income.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____

If you answered yes to any of the above, attach a copy of the initial benefits statement or payment details for each type of income.

## 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
<input type="checkbox"/> Individual Disability Insurance:	_____	_____
<input type="checkbox"/> Individual Life Insurance	_____	_____
<input type="checkbox"/> Creditor / Loan Insurance	_____	_____
<input type="checkbox"/> Critical Illness Insurance	_____	_____
<input type="checkbox"/> 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.

## 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 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 benefits 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 Life 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.

## 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 <b>X</b>	

# 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](http://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	Your Canada Life ID number	Date (mm/dd/yyyy)
Telephone Number	Email Address	Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim.
Your name (please print)	Signature 	

