

LiUNA!care

LOCAL 183™

BUILDING HEALTHY FUTURES

LONG TERM DISABILITY



Policy N° - 158000

Long Term Disability Benefits

If you become disabled while covered, reached the maximum benefit duration of short term disability benefits, are under age 65, and remain totally disabled and unable to return to active full-time employment, you may be entitled to long term disability benefits.

Eligibility Requirements

- You must be a Member with plan coverage on the date your disability started.
- You must be disabled from work for more than the waiting period of 104 weeks.
- You must be totally disabled from any gainful employment – **Totally Disabled** means that solely because of a non-occupational illness or non-occupational accidental bodily injury, you are unable to work and continue the duties of any occupation for which you are suited because of your education, training, or experience.
- You must totally disabled and under the ongoing care of a licensed doctor (M.D.) in Canada.
- Your disability must be a result of a non-occupational illness or injury.
- If your disability was caused by or contributed by a motor vehicle accident which occurred in the province of Ontario or Quebec, this is a policy exclusion, and you are not eligible for this benefit.
- There are certain exclusions and limitations – please refer to the benefit plan booklet for greater detail.

If you are currently on short term disability benefits, LiUNAcare Local 183 Health Management Services will provide you the long term disability application forms when required and assist you with the application process. If you are disabled from working and not in receipt of short term disability benefits, contact LiUNAcare Local 183 Health Management Services.

Benefit

- If you have met the eligibility requirements, you may be eligible for the following benefits:
 - A maximum monthly benefit of \$1,000 for the first five (5) years provided you remain totally disabled.
 - A maximum monthly benefit of \$600 after the first five (5) years provided you remain totally disabled.
 - The benefit is payable up to the maximum duration of ten (10) years, recovery, or attainment of age 65.

Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Complete and sign the **Employee Statement** and **Consent Form**.
3. Ensure the physician overseeing your medical care completes the **Initial Attending Physician Statement**.
4. There are additional forms and documentation required to initiate a claim - Contact LiUNAcare Local 183 Health Management Services for assistance.
5. Return the completed application to LiUNAcare Local 183 Member Health Management Services by.



Email:

memberhealthservices@liunacare183.com



Mail:

200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9



Fax:

416-240-7047

Please follow the steps in this guide to apply for disability benefits.

Your group plan requires you to notify Canada Life of your disability within a certain time after you become disabled. This means you should notify Canada Life of your disability as soon as possible. To notify Canada Life of your disability, you can fax or mail your employee statement, consent form, and any other information you want to provide about your claim to the Canada Life Disability Services Office. Fax numbers and addresses of all Canada Life Disability Services Offices are on our website or you can contact your plan administrator for this information.

STEP ONE - EMPLOYEE STATEMENT AND CONSENT FORM

Complete the employee statement and consent form if you are applying for Short or Long Term Disability benefits, Life Waiver of Premium benefits, or Early Referral Services.

The completed employee statement provides us with general information about you and your medical details and provides Canada Life with notice of your disability claim.

A consent form is included with your employee statement. Your signature on the consent form is necessary as it gives us permission to obtain additional information from your employer, other insurers, your doctor, hospitals, or other care providers to help us review your claim.

We may share personal information, like your functional abilities, restrictions or limitations with your employer when discussing your return to work. We may share medical information, like your diagnosis, test results, or medical reports with your employer's Occupational Health Services if they are involved with your disability claim(s).

STEP TWO - MEDICAL INFORMATION

Your doctor will need to provide us with medical information about how your condition(s) prevents you from working. Print the medical questionnaire form applicable to your condition and have your doctor complete it. Your doctor can fax or mail the completed form to Canada Life directly.

You can choose the other conditions form if your condition is not a specific diagnosis listed or you can choose the "print all condition forms" if you are unsure which form to bring to your doctor.

EMPLOYER STATEMENT

Your employer will send an employer statement to Canada Life on your behalf. This statement confirms your coverage, job information, monthly earnings and other information necessary to assess and administer your disability claim.

If your plan administrator has not provided the employer statement when we receive your employee statement, we will contact your employer directly for this information.

OUR RESPONSIBILITY

We will begin our review of your disability claim when we receive your employee statement in the Disability Management Services Office. At that time, a Canada Life representative will contact you to let you know what you can expect throughout the claim process and to obtain any further information that may be required.

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: _____

Your Plan Number: _____ Your Canada Life ID Number: _____

YOUR 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: _____

Is your mailing address the same as above? Yes No If no, please provide mailing address.

Mailing Address: _____

City / Town: _____ Province / Territory: _____ Postal Code: _____

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 message with callback information at that number.

Cell Phone: _____ Confidential

Work Phone: _____ Ext: _____ Confidential

Email Address: _____

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

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): Regular duties and hours Modified duties 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? No Yes

CLAIM INFORMATION (con't)

Is your condition the result of an accident? No Yes If yes, answer the following questions:

When 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? No Yes Hospital Name: _____

Date admitted: _____ (mm/dd/yy) Date discharged: _____ (mm/dd/yy) **OR** Still hospitalized

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

Date of surgery: _____ Type of surgery: _____

Is recovery from your surgery the only medical condition keeping you from working? No Yes Unknown

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? No Yes 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). No Yes
- Any other income? Examples: automobile accident benefits, employer sponsored STD or sick leave benefits, Employment Insurance benefits, retirement or pension plan income. No Yes.

If you answered yes, attach a copy of the initial benefits statement for each type of other income.

- Self employment or other employment income. No Yes.

If you answered yes, attach a copy of your pay/salary details.

All of the income described above is referred to as "reportable income".

If you have any of the following coverage 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 Issue 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:

--	--	--	--	--	--	--	--	--	--	--	--

The diagram shows a routing slip with three sets of four boxes each, separated by vertical lines. The first set is labeled 'TRANSIT#', the second 'INSTITUTION#', and the third 'ACCOUNT#'. Below the boxes, there are labels: 'TRANSIT#' under the first set, 'INSTITUTION#' under the second, and 'ACCOUNT#' under the third.

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: _____

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.
- 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	Print your name	Telephone number
Your Canada Life ID number	Email Address	<small>Enter your email address if you would like Canada Life to communicate with you by secure email about your Disability Services claim.</small>
Your signature 		Date (mm/dd/yyyy)



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 or you can write to Canada Life's Chief Compliance Officer.

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. _____

Part 1: Patient Authorization

Name (please print): _____ Date of birth: Year _____ Month _____ Day _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone Number (including area code): (_____) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life for the purposes stated above. I acknowledge that my consent enables Canada Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date _____

Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). **Please attach a copy of all consultation, operative and pathology reports. Do not provide genetic test results.**

Date of cancer diagnosis: Year _____ Month _____ Day _____

Site of the tumor: _____

Type of tumor: _____

Histology and staging: _____

2. **History**

Date symptoms first appeared: Year _____ Month _____ Day _____

Has patient ever had the same or similar condition? Yes No

If yes, please specify diagnosis and dates of treatment. _____

Describe current symptoms: _____

First visit for these symptoms: Year _____ Month _____ Day _____

3. Current Height: _____ Current Weight: _____ Weight loss/gain to date: _____

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 _____

Treatment: Include information on all treatments to date and future treatment plan, inclusive of:

Surgery: _____

Radiation: _____

Hormones: _____

Chemotherapy: _____

6. **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: _____

7. Describe response to therapies to date: N/A partial Complete

Describe all comorbid conditions: _____

Describe any "post therapy" sequelae: _____

Prognosis: _____

8. 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

9. 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.

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 _____

10. 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.**

11. We would appreciate any additional comments that would help us to better understand your patient and their condition.

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

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)	

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. _____

Part 1: Patient Authorization

Name (please print): _____ Date of birth: Year _____ Month _____ Day _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone Number (including area code): (_____) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date _____

Part 2: Attending Physician's Statement

1. **Diagnosis** (please provide copies of all relevant clinical notes, test results and consultation reports on file. **Do not provide genetic test results**)

Primary: _____

Secondary: _____

Date symptoms first appeared Year _____ Month _____ Day _____

Date of first visit Year _____ Month _____ Day _____

Date patient's condition first prevented them from working: Year _____ Month _____ Day _____

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: Weekly Monthly Other _____

Date of hospital inpatient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of hospital outpatient admission: Year _____ Month _____ Day _____

Name of hospital: _____

Subjective symptoms (including severity/frequency/duration): _____

2. **Findings**

Chest pain of cardiac origin Syncope Fatigue Dyspnea due to vascular congestion or hypoxia

Psychophysiologic Other (please specify): _____

BP readings over last 6 months (including dates) _____

Current height _____ Current weight _____ Weight loss/gain to date _____

Current status? Stable Improving Regressing

3. **Laboratory tests** (completed/scheduled) - please include copies of relevant test results.

EKG Year _____ Month _____ Day _____
Echocardiogram Year _____ Month _____ Day _____
Stress Thallium Test Year _____ Month _____ Day _____
Pulmonary Function Test Year _____ Month _____ Day _____
Blood Test Year _____ Month _____ Day _____
X-rays Year _____ Month _____ Day _____
Angiogram Year _____ Month _____ Day _____

4. **Treatment**

Medications (dose / frequency / date prescribed): _____

Other treatment (please describe): _____

Surgery date (past): Year _____ Month _____ Day _____ Type: _____

Surgery date (future): Year _____ Month _____ Day _____ Type: _____

Other treating physicians: _____

Is patient compliant with prescribed treatment? Yes No If No, please explain: _____

Has your patient been enrolled in a cardiac rehab program? Yes No

If yes, provide details: _____

5. **Restrictions and limitations**

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

Level 1 (no limitation) Level 2 (mild impairment) Level 3 (moderate impairment) Level 4 (severe impairment)

	Weight	Frequency	Duration	What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?
Lifting/Carrying	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			
Pushing/Pulling	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			How does this affect the patient's ability to perform activities of daily living?
Standing	_____ hours			
Walking	_____ blocks			
Driver's license revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

6. **Return to work plans:**

Prognosis for recovery: _____

Expected date patient will return to their own occupation: Year _____ Month _____ Day _____

If unknown, please indicate the next follow up date: Year _____ Month _____ Day _____

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) _____

Assessment and treatment are complicated by: (please select and explain in the space provided below)

Significant emotional or behavioral disorder such as depression, anxiety, etc.

Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

Work-related issues (please describe if known) _____

Substance abuse _____

Other (please describe) _____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)?

Yes No

Is patient a suitable candidate for vocational rehabilitation? Yes No

If yes to either of the above, please specify: _____

7. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

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)	

Attending Physician's Statement

Mental Health
Conditions

Section A Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT			
Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)	
Address (Street, City, Province, Postal Code)			
Employer's Name	Group Plan Number	Canada Life Employee Identification Number	Date of Birth (dd/mm/yyyy)
Date Last Worked (dd/mm/yyyy)	Date Returned to Work or Expected Return to Work Date, if known (dd/mm/yyyy)	Please provide your: Height: _____ Weight: _____	
<p>I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life and administering the group benefits plan. Medical and health information excludes genetic test results.</p> <p>I acknowledge that the personal information is needed by Canada Life Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s). This consent may be revoked by me at any time by sending a written instruction.</p> <p>I understand that I am responsible for any fees related to the completion of this form.</p> <p>I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.</p>			
Plan Member/Employee Signature		Date of Consent (dd/mm/yyyy)	
Section B Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR			
I am the: Attending Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____			
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE			
1. Diagnosis			
Primary: _____			
Secondary: _____			
Is this condition related to: Occupational Illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> If so, date of event: (dd/mm/yyyy) _____			
Details: _____ _____			
Date of first visit to you pertaining to this condition (dd/mm/yyyy) _____		First date of work absence due to this condition: (dd/mm/yyyy) _____	
Has the patient been treated for this same or similar condition in the past?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, date: (dd/mm/yyyy) _____		By whom: _____	
Have you completed any other disability claim forms recently for this patient?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.)			

2. Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: _____

3. Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy / Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration / Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect / Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight / Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Observations or comments supporting the above: _____

4. Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

<input type="checkbox"/> Workplace Issues	<input type="checkbox"/> Social / Family Issues	<input type="checkbox"/> Financial / Legal Problems
<input type="checkbox"/> Physical Condition	<input type="checkbox"/> Alcohol / Drug Abuse	<input type="checkbox"/> Medication Side Effects
<input type="checkbox"/> Pain Perception	<input type="checkbox"/> Coping Skills	<input type="checkbox"/> Personality / Motivation
<input type="checkbox"/> Other		

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

5. Investigations

Please attach copies of all relevant:

- test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- consultation reports
- do not provide genetic test results

Are tests / investigations / consultations pending? Yes No Date report expected: (dd/mm/yyyy) _____

Does the patient have an appointment booked with a specialist(s) in the near future? Yes No

Name of Specialist

Specialty

Date of Appointment: (dd/mm/yyyy)

1. _____

2. _____

Reason for requesting the consultation: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes No Don't know

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

6. Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7. Hospitalization

Is/was the patient hospitalized? Yes No Is future hospitalization anticipated? Yes No

Date admitted (dd/mm/yyyy)

Date discharged (dd/mm/yyyy)

Institution Name

1. _____

2. _____

8. Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

9. Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

10. Overall Response to Treatment

Please describe the response to treatment to date: Complete Partial None Too soon to tell

Is the patient following the recommended treatment program? Yes No

Please explain: _____

Are there any plans to change or augment the current treatment program? Yes No

If so, please explain: _____

11. Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain: _____

Please provide the patient's prognosis for improvement: _____

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis: _____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

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)	

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. _____

Part 1: Patient Authorization

Name (please print): _____ Date of birth: Year _____ Month _____ Day _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone Number (including area code): (_____) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date _____

Part 2: Attending Physician's Statement

1. **Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports. Do not provide genetic test results.)**

Primary: _____

Secondary: _____

Date symptoms first appeared Year _____ Month _____ Day _____

Date patient's condition first prevented them from working Year _____ Month _____ Day _____

Date of first visit for treatment or consultation Year _____ Month _____ Day _____

Has patient ever had the same or a similar condition? Yes No Unknown

If yes, state when and describe: _____

Is condition a result of an injury due to an accident? Yes No

If yes, please describe. _____

Current height _____ Current weight _____ Weight loss / gain to date _____

Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown

If yes, have Workers' Compensation Board/CSST forms been completed? Yes No

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: Weekly Monthly Other _____

Date of hospital inpatient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of hospital outpatient admission: Year _____ Month _____ Day _____

Name of hospital: _____

Other treating physicians: _____

Pending referrals to specialists: _____

2. Please outline all objective studies performed / scheduled (X-rays, laboratory data, C.T. scans, etc.) and **attach copies of each report**.

Date	Procedure	Results

3. Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings				Severe	Moderate	Mild	Absent
Pain					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Spasm					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Atrophy					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Tendon Reflexes					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Change					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Deficit					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straight Leg Raising Limitation					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of Motion Limitation					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Treatment

Medications (dose / frequency / date prescribed): _____

Physiotherapy (type, frequency, dates): _____

Surgery date (past): Year _____ Month _____ Day _____ Type: _____

Surgery date (future): Year _____ Month _____ Day _____ Type: _____

Other treatment: _____

Is patient compliant with prescribed measures? Yes No If No, please explain: _____

5. Limitations and Restrictions

Please indicate in the space provided if this patient is able to perform the following actions:

(Frequently (F), Occasionally (O) or Not at all (N):)

Drive Bend Squat Kneel Climb Reach (above shoulders) Reach (below shoulders)

6. Prognosis / Return to work plans:

Prognosis for recovery: _____

Expected date patient will return to their own occupation: Year _____ Month _____ Day _____

If unknown, please indicate the next follow up date: Year _____ Month _____ Day _____

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work). _____

Assessment and treatment are complicated by: (please select and explain in the space provided below)

- Significant emotional or behavioral disorder such as depression, anxiety, etc.
- Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations
- Work-related issues (please describe if known) _____
- Substance abuse _____
- Other (please describe) _____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services? Yes No

Is patient a suitable candidate for vocational rehabilitation? Yes No

If yes to either of the above, please specify: _____

7. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

Notice to Physician

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Email Address		
Signature	Date Signed (dd/mm/yyyy)	

Other Conditions

Attending Physician's Statement - Long Term Disability Claim

Section 1 Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)																								
Address (Street, City, Province, Postal Code)																										
Employer's Name	Group Plan Number	Canada Life Employee Identification Number																								
Date Last Worked (dd/mm/yyyy)		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy)																								
<p>Please list your present medications:</p> <table> <tr> <td>Name of Medication</td> <td>Dosage (mg)</td> <td>How Often?</td> <td>Please provide your:</td> </tr> <tr> <td>1. _____</td> <td>_____</td> <td>_____</td> <td>Height: _____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>_____</td> <td>Weight: _____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>_____</td> <td></td> </tr> <tr> <td>4. _____</td> <td>_____</td> <td>_____</td> <td>Dominant Hand:</td> </tr> <tr> <td>5. _____</td> <td>_____</td> <td>_____</td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> </tr> </table>			Name of Medication	Dosage (mg)	How Often?	Please provide your:	1. _____	_____	_____	Height: _____	2. _____	_____	_____	Weight: _____	3. _____	_____	_____		4. _____	_____	_____	Dominant Hand:	5. _____	_____	_____	Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?	Please provide your:																							
1. _____	_____	_____	Height: _____																							
2. _____	_____	_____	Weight: _____																							
3. _____	_____	_____																								
4. _____	_____	_____	Dominant Hand:																							
5. _____	_____	_____	Left <input type="checkbox"/> Right <input type="checkbox"/>																							

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature

Date of Consent (dd/mm/yyyy)

Section 2 Attending Physician's Statement TO BE COMPLETED BY THE PHYSICIAN

I am the: Family Physician Consulting Specialist Other (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: _____

Secondary and/or Complications: _____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____

Is this condition due to: Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____	Auto Accident Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____								
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/>									
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____									
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____								
Treatment									
e.g. Special Programs, Therapies, Medications: (if not noted by patient in Section 1) 									
Frequency of Visits: Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/> (describe) _____									
Date of last visit: (dd/mm/yyyy) _____									
Has the patient been treated for this same or similar condition in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date: (dd/mm/yyyy) _____ Treatment provider: _____									
Is the patient following the recommended treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> Please elaborate: _____									
Response to Treatment									
Please describe the response to treatment to date: Complete <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> Too soon to tell <input type="checkbox"/>									
Are there any plans to change or augment the current treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please explain: _____									
Hospitalization									
Is/was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>		Is future hospitalization planned? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Date of admittance (dd/mm/yyyy)		Date of discharge (dd/mm/yyyy)							
1. _____		_____							
2. _____		_____							
3. _____		_____							
If surgery was/will be performed, please provide date(s) and description of surgery(s): <table style="width: 100%; border-collapse: collapse;"><tr><td style="width: 25%;">Date (dd/mm/yyyy)</td><td style="width: 75%;">Description</td></tr><tr><td>1. _____</td><td>_____</td></tr><tr><td>2. _____</td><td>_____</td></tr></table>				Date (dd/mm/yyyy)	Description	1. _____	_____	2. _____	_____
Date (dd/mm/yyyy)	Description								
1. _____	_____								
2. _____	_____								

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes No

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes No Please elaborate:

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician

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