Long Term Disability Income Benefit

Employee's Guide

THE
Great-West Life
ASSURANCE COMPANY

THE Great-West Life ASSURANCE COMPANY

Long Term Disability Income Benefits

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 notice form, and any other correspondence about your claim, should be submitted directly to Great-West Life by mail or fax. Please do not submit the Employee Statement, Physician Statement or any other portion of this package to OASSIS. If you have questions concerning the status of your claim, you may contact the office by phone. The contact information for this office is provided below:

The Great-West Life Assurance Company
Scarborough DMSO
55 Town Centre Court Suite 400
Toronto ON M1P 5B5

Phone: 416-290-3770
Toll Free: 1-800-761-7444
Fax: 1-888-214-4401

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

Employee's Statement, Authorization and Physician's Statement

To begin the claim submission process, you should complete the Employee's Statement and authorization request included in this guide. In addition, please have your doctor complete the physician's statement. These forms should be submitted as soon as you are aware that your disability will continue beyond the end of the waiting period. In these situations, we recommend submitting your claim **at least 8 weeks** before the end of the Waiting Period. **Benefits may be delayed if these forms are submitted later than this.**

1. Employee's Statement

The Employee's Statement 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 Plan 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 the form that is most appropriate to your claimed condition. If you have undergone any tests or seen any specialists, please ensure that your physician includes copies of the results and the reports.

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 guide, 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 provide you with any needed medical questionnaires for your physician to complete.

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. You will also be asked to follow-up with your Physician to ensure timely completion of medical questionnaires.

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.

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.

THE Great-West Life ASSURANCE COMPANY

Long Term Disability Income Benefits
Employee's Statement

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   City _____ Province _____ Postal Code _____

   Telephone: Home (_____) _____ ☐ confidential Work (_____) _____ ☐ confidential

   Cell (_____) _____ ☐ confidential

   If you wish us to leave a detailed message with personal information about your claim at a number, check the box marked "confidential" beside that number. Otherwise, we will only leave a general message with callback information at that number.

   Email address: _____

   If you would like Great-West Life to communicate with you by email about your disability claim, please fill in your email address. Emails Great-West Life sends to this address will be sent securely using Proofpoint Secure Email.

2. Your GWL Employee Identification Number _____

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

3. Social Insurance Number _____

   If your employer pays for all or any part of your disability benefits coverage, any benefits payable may be subject to income tax. If this applies to you, please provide your Social Insurance Number for income tax reporting purposes. Your Social Insurance Number may also be used as an identification number where required in the administration of benefits.

4. Date of birth: Year _____ Month _____ Day _____

Plan Information

1. Plan Sponsor Name: **OASSIS**
2. Group Plan Number: **169021**

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 Yes	I have applied No	I am receiving Yes	I am receiving 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, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes _____ Plan Number ☐ No

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

DIRECT DEPOSIT AUTHORIZATION

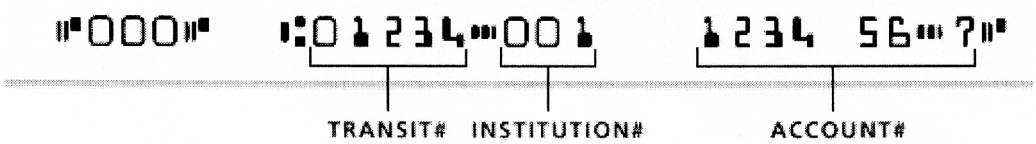
Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account**.

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.



TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
___ ___ ___ ___ ___	___ ___ ___	_____

NAME OF BANK, TRUST CO, CREDIT UNION, ETC.

DATE

SIGNATURE OF EMPLOYEE

THE Great-West Life ASSURANCE COMPANY

Application for Disability Income Benefits
Employee's Authorization Request

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file 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. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that 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.

Except for audit purposes, the authorizations 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 Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

169021

Group Plan Number

GWL Employee Identification Number

Print Employee Name

Employee Signature

Date

Telephone Number

THE Great-West Life ASSURANCE COMPANY

The patient is responsible for any fees related to the completion of this form.

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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) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)		

Plan Sponsor Name	Group Plan Number	GWL Employee Identification Number	Date of Birth (dd/mm/yyyy)
OASSIS	**169021**		

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy)

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1.		
2.		
3.		
4.		
5.		

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West 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 DOCTOR

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

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

_____

Secondary and/or Complications: _____

_____

_____

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

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Is this condition due to: Occupational Illness/injury Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) _____	Auto Accident Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) _____
Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐ 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 ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) _____ Treatment provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

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

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

If so, please explain: _____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

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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**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Functional Abilities

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities:

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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:

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)	

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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) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Plan Sponsor Name	Group Plan Number	GWL Employee Identification Number	Date of Birth (dd/mm/yyyy)
OASSIS	**169021**		

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: _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West 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 understand that I am responsible for any fees related to the completion of this form.

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 B	**Attending Physician's Questionnaire** **TO BE COMPLETED BY THE DOCTOR**

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

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: _____

_____

Secondary: _____

_____

Is this condition related to: Occupational Illness/injury ☐ Auto accident ☐ 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 ☐ No ☐

If yes, date: (dd/mm/yyyy) _____ By whom: _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.)

_____

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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	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision Making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect / Mood	☐	☐	☐	☐
Insight / Judgment	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

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:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems

☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects

☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

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

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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

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

Does the patient have an appointment booked with an 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 ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

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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 ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

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.

Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address		Telephone # (+ Area Code)
Email Address		Fax # (+ Area Code)
Signature or Stamp		

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		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If Arthritic Condition: ☐ In Remission ☐ Continuously Active ☐ Stable
☐ Seasonally Active ☐ Intermittently Active ☐ Progressive

If Fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

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**

		Hours at one time					Total hours during day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
☐ No restriction	☐ Repetitively - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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?

_____

_____

_____

_____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Email Address: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cardiac Form

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. **169021**

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 Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West 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)

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 _____ blocks Driver's license revoked? ☐ Yes ☐ 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?

_____

_____

_____

_____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Email Address: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cancer Form

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. 169021

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 Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West 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.**

   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: _____

Clear

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 his or her condition.

    _____

    _____

    _____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Email Address: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____

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