

**Short Term  
Disability  
Income  
Benefit**

*Employee's Guide*



This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted as soon as possible after the onset of your disability. **Your notice form, and any other correspondence you may wish to provide 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

### 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.

### 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 this form. It requests general information about your condition.

## WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

### Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance coverage began, your job duties and earnings. We have asked your employer to supply this information directly to us.

### Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

### Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

### Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

## Short 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**

#### 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. Please provide the name(s) and telephone number(s) of your attending physician(s).

\_\_\_\_\_

**Financial**

1. Have you applied for, or are you receiving the following:

	I have Applied		I am Receiving		Amount
	Yes	No	Yes	No	
Canada Pension Plan/Quebec Pension Plan Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Workers' Compensation Board Benefits (or similar plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employment Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Automobile Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Sponsored Retirement / Pension Plan Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Self Employment Income or any other Employment Income			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

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 THE 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# INSTITUTION#	ACCOUNT#
TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

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

DATE

SIGNATURE OF EMPLOYEE

## 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](http://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

## Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

### Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)				
Plan Sponsor Name <b>OASSIS</b>		Group Plan Number <b>169021</b>	GWL Employee Identification Number	
Height	Weight	Date of Birth (dd/mm/yyyy)		
Last Date Worked (dd/mm/yyyy) _____		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____		
<p>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.</p> <p>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).</p> <p>This consent may be revoked by me at any time by sending a written instruction.</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) _____		

### Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

- If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete **Page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete **Pages 1 and 2 in full**.

**PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE**

Primary Diagnosis: _____		
Secondary and/or Complications: _____		
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____		Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>
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) _____	
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____	
<b>Hospitalization</b> Is/was patient hospitalized <input type="checkbox"/> or had day surgery <input type="checkbox"/> Date of admittance (dd/mm/yyyy): _____ Date of discharge (dd/mm/yyyy): _____ Institution Name: _____		
If surgery was performed please provide date and description of surgery: Date (dd/mm/yyyy): _____ Description: _____		
Treatment (drug, dosage, physiotherapy, other): _____ _____		
Prognosis Please provide the prognosis for recovery: _____ _____		

**Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks**

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

If yes, date (dd/mm/yyyy): \_\_\_\_\_ Treatment Provider: \_\_\_\_\_

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

Frequency of Visits:  Weekly  Monthly  Other \_\_\_\_\_

**➡ 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

**If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.**

Name of Specialist: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

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

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the patient following the recommended treatment program? Yes  No

**Prognosis** Please provide the prognosis for recovery: (if not completed on page 1)  
\_\_\_\_\_  
\_\_\_\_\_

**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)	



[www.greatwestlife.com](http://www.greatwestlife.com)