canada life™

Disability Income Benefits Employee Statement

To begin your claim submission:

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

NOTE: Canada Life takes the submission of fraudulent claims seriously and will verify the accuracy of the information given in support of your claim.

☐ **I certify the information given on this claim form is true, correct, and complete to the best of my knowledge.**

Your employer's name: IATSE 891 EMPLOYEE LIFE AND HEALTH TRUST

Your group plan number: 58199 Your Canada Life ID number: ____________

Your personal information

First Name: ____________ Middle Initial: ____ Last Name: ____________

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other Date of Birth: ____________

Social Insurance Number: ____________

Your Social Insurance Number is required as your disability benefit may be subject to income tax deductions.

Home Address: ____________

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

Work location (City / Town and Province / Territory): ____________

Home Phone : ____________ ☐ Confidential

Cell Phone: ____________ ☐ Confidential

Check the confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Email Address: ____________

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

Your employment information

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

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

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

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

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

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

What aspects of your job are you able to do?

____

____

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

____

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Your medical information

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

____

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

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

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

Provide details of the accident:

____

____

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

Your treatment information

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

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

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

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

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

____

____

____

Primary healthcare provider:

Provider's name: ____________________ Specialty: ____________________

Address: ____

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

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

Provider's name: ____________________ Specialty: ____________________

Address: ____

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

Provider's name: ____________________ Specialty: ____________________

Address: ____

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

Please attach a separate sheet if additional space is required

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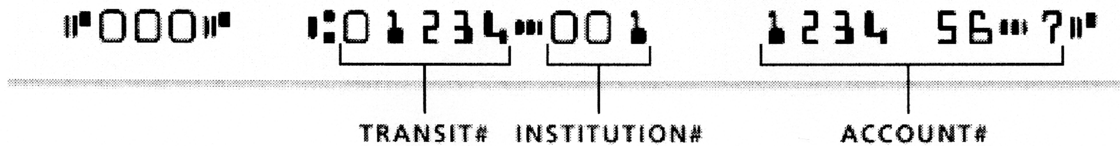
Direct deposit

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

If this space is left blank, previously provided banking information for other benefits under this group plan (i.e. Healthcare or Dentalcare) will be used for any disability income benefits payable.

Name of bank/credit union: ____________________

Transit number: ☐☐☐☐☐ Institution number: ☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐☐☐☐



Your financial information

Any income you receive must be reported to Canada Life. Have you applied for, or are you receiving any income either as a result of your disability or otherwise? (check no or yes):

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

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

Other coverage

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

	Plan/Policy #	Insurance Company
☐ Individual Disability Insurance:	______	______
☐ Individual Life Insurance	______	______
☐ Creditor / Loan Insurance	______	______
☐ Critical Illness Insurance	______	______
☐ 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.*

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Income declaration and reimbursement agreement

I understand that:

- I am required to apply for disability benefits that I or another member of my family might become entitled to receive because of my disability, and that I may be asked by Canada Life to reapply or appeal decisions refusing my application(s) where considered appropriate.
- During the time it takes for my application for these other disability benefits to be accepted, or my entitlement to any other reportable income to be reviewed, Canada Life will continue paying me amounts equivalent to the disability benefit payments under the Group Plan (the "Advance"). The terms "other disability benefits" and "other reportable income" refer to any of the types of disability benefits and other income mentioned under the Offset, All Source Maximum, Coordination of Benefits and Subrogation and Right of Recovery provisions under the Group Plan, as well as any other amounts including damages for loss of income, that I may receive or become entitled to receive as a result of my disability.
- If I am entitled to receive disability benefits or any other reportable income, this may result in an overpayment ("Overpayment") that I will be required to pay back to Canada Life. I specifically give up my rights under any law that qualifies the Advance, the Overpayment, the other disability benefits, or any other reportable income, as property exempt from seizure.
- Canada Life may reduce my disability benefit payments by the amount of other disability benefits or other reportable income that I receive or become entitled to.

I agree to:

- Notify Canada Life within 15 days of receipt of other disability benefits payments or any other reportable income.
- Repay Canada Life within the time frame Canada Life advises me of after I am notified of the Overpayment amount or within a longer period if Canada Life agrees in writing. I understand that if the Overpayment is not repaid when due, Canada Life may take all necessary steps to recover the Overpayment, including withholding the payment of, or recovering the Overpayment from, any benefits payable under the Group Plan.

Declaration

☐ I declare the information I've entered is accurate. I understand and agree to the terms in the Income declaration and reimbursement agreement section. I also acknowledge that I need to print, sign, and submit my Consent form to Canada Life.

Your group plan number	Your Canada Life ID number	Date (mm/dd/yyyy)
Your name (please print)	Signature X	

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Your consent

Before we can process your claim for benefits, you must read this agreement and sign in the *signature* box below.

Sharing your personal information

We collect, use and disclose your personal information to:

- investigate and assess your claim
- administer your claim and the group benefits plan
- work out a rehabilitation plan to get you back to work
- audit the assessment of the claim
- manage internal data for analytics purposes

We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Insurance and reinsurance companies
- Administrators of the plan, of government benefits and of other benefit programs
- Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
- Your employer's occupational health services
- Your union representative
- Service providers and other organizations working with us, or on behalf of the other parties mentioned above. We may use service providers outside Canada.
- An auditor authorized by us, your employer, plan sponsor or their agent

Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only persons with access to the information are:

- people working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim
- those whom you've given access
- those authorized by law both within Canada and in any other jurisdiction where your personal information is held.

For a copy of our Privacy Guidelines see **canadalife.com** or you can write to Canada Life's Chief Compliance Officer.

By signing below, you confirm that:

✓ You have read, understand and agree with the contents of this form and authorize us to collect and disclose your personal information.
✓ Except for audit purposes, your authorization is valid for the duration of your claim or until you cancel it in writing.
✓ All statements you have made about your claim are true and complete
✓ A photocopy or electronic copy of this authorization is as valid as the original.

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

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