THE
Great-West Life
ASSURANCE COMPANY

Employee's Statement
Short Term Disability Income Benefits

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

These claim forms must be completed and submitted at the onset of disability directly to GWL as follows:

Maritimes/Quebec/Ontario	**All Other Provinces**
Montreal Disability	Winnipeg Disability
Management Services Office	Management Services Office
Great-West Life	Great-West Life
1140 - 2001 University St.	P.O. 1055
Montreal, QC H3A 1T9	Winnipeg, MB R3C 2X4

1. **Notice of Claim**

   The Notice of Claim 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 Policy Number on all correspondence.**

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 a doctor to complete this form and to include a copy of your **clinical notes, consultation reports and test results**. 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 upon receipt of the completed forms from you, your attending physician and your employer.

During the course of your claim, a Great-West life representative may telephone you to obtain information about your job, education and employment history, medical history, current disability and other relevant information that will help to better understand your situation. It is also possible that a medical coordinator and/or a rehabilitation consultant contact you to develop a return to work plan. Information may be required about certain other sources of income that could affect the amount of your benefit.

GWL's assessment is based on the medical evidence provided and information gathered from you and other sources which is then compared to the essential duties of your job.

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 supports your inability to work. This information must be supplied by a doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life initiates a request for information directly from a doctor, we will offer to pay a correspondence fee for it.

You are required to call and notify Great-West Life and your supervisor of your return to work date. If you belong to a safety sensitive or critical position you are also required to contact Occupational Health Services.

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NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First ____________ Initial ________ Last ________________

   Address: Street & Number ________________________________

   P.O. Box ________________________________

   City ____________ Province ____________ Postal Code ________

2. Telephone: Home (____) ____________ Work (____) ____________

   Your PIN Number ________________________

   Your PIN 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 ________

Employer Information

1. Your Employer's Name: **CN**

   Address: Street & Number **935 DE LA GAUCHETIERE ST. WEST, SUITE 700**

   City **MONTREAL** Province **QC** Postal Code **H3B 2M9**

2. Group Policy Number **51978**

   Supervisor Name: ________________________ Phone No. ____________

Claim Information

1. What is the nature of your condition? ________________________________

2. Is disability due to an accident? ☐ Yes ☐ No

   Date accident occurred Year ____ Month ____ Day ____ Was it work related? ☐ Yes ☐ No

   Where and how did it occur?

   ____

   ____

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		
	Yes	No	Yes	No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☐	☐	☐	$ ______
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ ______
Employment Insurance Benefits	☐	☐	☐	☐	$ ______
Automobile Insurance Benefits	☐	☐	☐	☐	$ ______
Any other Disability Benefits	☐	☐	☐	☐	$ ______
Employer Sponsored Retirement / Pension Plan Income	☐	☐	☐	☐	$ ______
Self Employment Income or any other Employment Income			☐	☐	$ ______
Any other income	☐	☐	☐	☐	$ ______
CN Pension Plan Benefits	☐	☐	☐	☐	$ ______

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 ☐ No If so, please provide your plan number: ______

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

Date: ______ Signature: ______

DIRECT DEPOSIT AUTHORIZATION

You can have your benefit payments automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life. If you'd like to take advantage of Electronic Funds Transfer, please fill in the information below.

Effective ______ (date) please deposit my payments to the following account

☐ Savings Account, (please attach your bank identification information/form)

☐ Chequing Account, (please attach sample cheque marked "VOID")

PLEASE PRINT

NAME OF BANK, TRUST CO., CREDIT UNION, ETC.	TRANSIT NO. INSTITUTION NO. ACCOUNT NO.
BRANCH ADDRESS	NAME IN WHICH ACCOUNT IS HELD
CITY OR TOWN & PROVINCE POSTAL CODE	

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

SIGNATURE OF EMPLOYEE ______ DATE ______

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Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, 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.

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;
- Great-West Life to exchange my personal information with my employer's occupational health department or third party occupational health services provider when relevant for the purpose of their determination of my fitness to return to work, as well as to assist with the assessment of my claim(s).

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.

Print Name	Signature
Date	Telephone Number

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Attending Physician's Statement

Short Term Disability Claim

The purpose of this Statement is to assist Great-West Life in making a decision on your patient's claim for disability benefits. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE. ***OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. PLEASE KEEP A COPY FOR YOUR RECORDS.***

Plan Member/Employee Information and Consent (To be completed by patient)

Plan Member Name (last, first, middle initial)		Home Phone #	Cell Phone #
Address (Street, City, Province, Postal Code)			
Employer's Name **CANADIAN NATIONAL RAILWAYS**		Plan contract number **51978**	PIN number
Height	Weight	Date of Birth (dd/mm/yyyy)	

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's signature Date (dd/mm/yyyy)

I hereby authorize Great-West, and any successor, to release this form, all reports and test results provided to Great-West Life in relation with this claim to CN Occupational Health Services (or its delegate) when relevant for the purpose of their determination of my fitness to return to work, as well as to assist with the assessment of my claim(s).
I understand that I am responsible for any fees related to the completion of this form.

_______________________________ _______________________
Plan Member's signature Date (dd/mm/yyyy)

Attending Physician's Statement

Diagnosis(es):	If Childbirth: Expected or Actual Delivery Date ____________ ☐ Vaginal ☐ C-Section
Is condition arising from employment? ☐ Yes ☐ No	
Date of First Visit for Current Condition (dd/mm/yyyy)	First Date of Work Absence due to Condition (dd/mm/yyyy)
Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other ____________	
Hospitalized? ☐ Yes ☐ No Name of Institution:	Date Admitted (dd/mm/yyyy): ____________ Date Discharged (dd/mm/yyyy): ____________
Treatment (drug dosage, physiotherapy, other):	
Describe current symptoms, severity and frequency and duration of each symptom:	
Describe clinical findings (i.e.: range of motion, tenderness, swelling, etc.):	

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Please attach copies of all relevant:
- Chart notes
- Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- Consultation reports

STOP **NOTE TO PHYSICIAN**
- If your patient has returned to work or will return to work within 6 weeks of the Last Date Worked, please indicate the date of return and proceed to end of form: Physician's Acknowledgement and Authorization.
- If not, please complete the entire form.

Continuation of Attending Physician's Statement for Absences that may be Greater than 6 Weeks

Has the patient been treated for this condition in the past? ☐ Yes ☐ No If yes, date (dd/mm/yyyy): ____________

Is drug or alcohol abuse impacting your patient's level of function? If so, please explain and advise if a referral to a treatment program has been initiated. Provide date, duration, frequency (day treatment or in-house program), and name of facility used for all current and any past alcohol/drug treatment.

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

Name of Specialist ____________ Specialty ____________ Date of Visit ____________

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

Based on your findings and clinical observations, please describe your patient's current cognitive restrictions and limitations.

If your patient is absent from work due to a physical disability, 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.

List physical restrictions and tolerances: ____________

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 ____________

To your knowledge is the patient following the recommended treatment program? ☐ Yes ☐ No

In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Physician's Authorization

____
Attending Physician (please print)

____
Certified Specialist

____
Address (number, street, city, province, postal code)

( ) ____________
Telephone number (include area code)

( ) ____________
Fax number (include area code)

____
Signature

____
Date signed (dd/mm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED FOR THE COMPLETION OF THIS FORM.

www.greatwestlife.com

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