

**Short-Term
Disability
Income
Benefit**

Employee's Statement

Great-West Life
your Benefits Solutions People



Please mail or fax to:

Mercon Benefits Services Inc.
#104, 13025 St. Albert Trail
Edmonton, AB T5L 5G5

Fax: (780) 455 - 6068

NOTICE OF CLAIM

Identification

1. Mr. Mrs. Ms.

Your Name: First _____ Initial _____ Last _____

Address: Street & Number _____

P.O. Box _____

City _____ Province _____ Postal Code _____

Telephone: Home (_____) _____ Work (_____) _____

2. Your GWL Employee Identification Number _____

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

3. Social Insurance Number _____

I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number only where required in the administration of my benefits.

Employee's Signature _____

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

Employer Information

1. Your Employer's Name: _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone Number: (_____) _____

2. Group Policy Number 159000 _____

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

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 or Life Insurance Coverage with Great-West Life, Canada Life or London Life? Yes No If so, please provide your policy 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. **All benefit payments covered under one policy number will be deposited into the same bank account.**

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 consult your bank for proper bank identification number.)
- 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

Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in 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 information in your files 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 information to investigate and assess your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments;
- Great-West Life to exchange my information with my employer, plan sponsor, or plan administrator when relevant for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims.

Except for audit purposes, this authorization 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 Employee's Statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

Print Name

Signature

Date

Telephone Number

8. 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 _____

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

10. **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: _____

11. **Surgery**

Surgical procedure performed: _____

Date of surgery: Year _____ Month _____ Day _____

Name of surgeon: _____

12. 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: _____

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

Physician's signature _____ Date _____

THE
Great-West Life
ASSURANCE  COMPANY

www.greatwestlife.com