canada life

Return completed form to:

CANADA LIFE ASSURANCE COMPANY
Winnipeg DMSO
100 Osborne Street North, P.O. Box 1055
Winnipeg, MB R3C 2X4
Tel.: 1 800 665-8622
Fax: 1 844 292-1931
Email: winnipeg.dmso@canadalife.com

In order to properly process your disability claim, the Claims Administrators must receive all portions of the claim paperwork completed in full and signed. Failure to do so may result in processing delays of your claim and affect payment. To expedite the process, please fax the GDIP claim request form to 1 844 292-1931 or send by email to winnipeg.dmso@canadalife.com with all necessary supporting documentation.

TO BE COMPLETED BY THE EMPLOYEE

Last Name:				First Name:			
Employee Number:		Date of Birth: (DD/MM/YY)		Job Position:			
Telephone Number:				E-mail address:			
Mailing Address:		City:		Province:		Postal Code:	
Manager's Name: *(if known)*				Manager's Telephone Number:			

Offset Provision: If income from the sources listed below is payable to you during the same period as any monthly income benefits payable under this claim, it will be deducted from those benefits.

Reportable Income	I have applied **YES**	I have applied **NO**	I am receiving **YES**	I am receiving **NO**		**Amount**
Canada Pension Plan/Quebec Pension Plan Benefits or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan:	☐	☐	☐	☐	$	Per month
Workers' Compensation Board Benefits (or similar plan) except for: a) permanent partial disability awards that were payable for each of the 12 months before a disability period; and b) benefits related to employment with another employer.	☐	☐	☐	☐	$	Per week
Periodic payments from any retirement plan except for that portion you were already receiving before the commencement of the disability period.	☐	☐	☐	☐	$	Per week/month
Indemnity benefits for loss of time to which you are entitled under any No-Fault Insurance Law or similar law requiring or providing such coverage for or on account of an accidental bodily injury or for which a private automobile insurance company is liable.	☐	☐	☐	☐	$	Per week/month
Any remuneration you may receive from the Employer or from any other employer, except for that portion you were already receiving before the commencement of the disability period.	☐	☐	☐	☐	$	Per week/month

1) I agree to notify Canada Life of any Reportable Income that I receive or become entitled to.
2) I agree to provide this notice within 30 days after Reportable Income is first received or awarded.
3) I recognize and accept my obligation to repay any benefits that are overpaid according to the terms of this Group Disability Income Plan as a result of my entitlement to Reportable Income, or otherwise. If my benefits are overpaid, I am responsible for repayment within 6 months, or within a longer period if agreed to by Canada Life. If I fail to fulfill this responsibility, I agree that further benefits may be withheld until the overpayment is recovered.

Signature: **Date:**

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Protecting Your Personal Information

At **The Canada Life Assurance Company (Canada Life)**, we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of **Canada Life** or in the offices of an organization authorized by **Canada Life**. This information about you may include medical and psychiatric information. We limit access to information in your files to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use information to investigate and access your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- **Canada Life** and its agents to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments.
- My Treating Physicians and/or any health care providers that I have consulted to disclose to **Canada Life** and its agents all medical and psychiatric information relevant to the assessment and administration of this claim. I further authorize **Canada Life** and its agents to communicate with my Treating Physicians and/or any health care providers that I have consulted and to disclose to them any and all medical and psychiatric information relevant to the assessment and administration of this claim.
- For the purpose of discussing rehabilitation and return-to-work planning, **Canada Life** and its agents to exchange information regarding my restrictions, limitations, capabilities and duration of the claim with my employer when necessary.
- For the purpose of discussing rehabilitation and return-to-work planning, **Canada Life** and its agents to exchange information regarding my restrictions, limitations, capabilities, medical information, and duration of the claim with ~~Air Canada Disability Management and/or~~ Occupational Health Services when necessary.
- **Canada Life** and its agents to release information about this claim to an auditor authorized by my employer or their agent at any time for the purpose of auditing the assessment of the claims.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that all information which I have or will provide to **Canada Life** and its agents with respect to this claim is true and accurate.

Employee Name (Please print)

Employee Signature

Date

In the event that a dispute arises with respect to this claim or to my continuing entitlement to income benefits, I authorize and direct that the Claims Administrators provide to the IAMAW Local Lodge (please insert Local Lodge number) _____ and its representatives any information and documents from this claim file that they request for the purpose of representing me in such dispute. I understand that this may include any and all medical and psychiatric information and documents included therein.

Employee Signature: _____

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Last Date Worked: (DD/MM/YY) _____
NOTE: If it was an Air Canada work-related illness/injury, be sure that a Workers' Compensation Board accident report has been completed.
Are you absent due to: Work-related illness/injury ☐ Yes ☐ No
Brief Description of illness/injury: _____
Date of Accident: (DD/MM/YY) Location of Accident:
Are you absent due to: Non work-related illness/injury ☐ Yes ☐ No
Brief Description of illness/injury: _____
Date of Accident: (DD/MM/YY) Location of Accident:

Treating Physician Information:

Name of Physician:			
Mailing Address:		Postal Code:	
Telephone Number:		Fax Number:	

List any physicians/care providers consulted for present condition (including specialists, physiotherapists, counsellors, EAP, etc.):

Name	Specialty	Address	Telephone

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- For the purpose of discussing rehabilitation and return-to-work planning, **Canada Life** and its agents to exchange information regarding my restrictions, limitations, capabilities, medical information, and duration of the claim with Air Canada Disability Management and/or Occupational Health Services when necessary.
- **Canada Life** and its agents to release information about this claim to an auditor authorized by my employer or their agent at any time for the purpose of auditing the assessment of the claims.

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I declare that all information which I have or will provide to **Canada Life** and its agents with respect to this claim is true and accurate.

_____ _____

Employee Name (Please print) Employee Signature

_____

Date

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In order for a claim to be qualified for Group Disability Income Plan (GDIP) benefits under the company's plan, the medical documentation must contain clinical findings and detailed medical information which establishes not simply the presence of a medical condition but rather that there is evidence of an impairment severe enough to prevent your patient/client from participating in work.

- **It is the employee's responsibility to provide medical information to support an application for income protection and to pay any costs incurred in obtaining this information.**
- **This is not a request for examination, but for information taken from your chart.**

EMPLOYEE NAME:	**ID:**	**DOB (DD/MM/YY)**

TO BE COMPLETED BY THE TREATING PHYSICIAN — **PLEASE PRINT CLEARLY**

Date patient first consulted for this disability (DD/MM/YY):			
Date of most recent visit (DD/MM/YY):			
Frequency of visits:	Once per week ☐	Every two weeks ☐	Other:
Date of hospitalization or surgery (past and/or present, if applicable):		Hospital:	
		Date of admittance:	
		Date of discharge:	
		Date of surgery:	
		Procedure:	
1 ° Diagnosis:		2 ° Diagnosis:	
Date symptoms first appeared for this disability (DD/MM/YY):			
Severity of condition:	☐ Mild ☐ Moderate ☐ Severe		
Are there any co-morbid conditions that may impede the recovery from this illness (e.g. diabetes)?			
Prognosis:			
DSM IV (if applicable):	Axis I (clinical syndrome):		
	Axis II (personality trait disorder):		
	Axis III (physical condition):		
	Axis IV (contributing psychosocial factors):		
	Axis V (GAF):		
Precipitating effects:	Are work related issues contributing to your patient's condition? ☐ Yes ☐ No (Please specify)		
Subjective symptoms:			
Objective signs:			
Is there a previous history of this illness?	☐ Yes ☐ No If "YES" state when and describe:		
Current medical status:	1st visit ☐	Improved ☐	Unchanged ☐ (please advise of change in treatment plan) / Worse ☐ (please describe the complications in Additional Comments section)

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TESTS - PLEASE PROVIDE COPIES OF ALL RELEVANT REPORTS WHICH MAY ASSIST IN ASSESSMENT OF CLAIM						
☐ Laboratory	☐ X-Ray	☐ Ultrasound	☐ CT Scan	☐ ECG	☐ Stress Test	☐ EMG
☐ Angiogram	☐ Endoscopy	☐ Bone Scan	☐ MRI	☐ Other		

REFERRALS - PLEASE PROVIDE COPIES OF ANY CONSULTATION/PROGRESS REPORTS

Referral to: _____ (name & specialty) Appt. Date _____ DD MM YY

Referral to: _____ (name & specialty) Appt. Date _____ DD MM YY

AWAITING REFERRAL ☐ **YES** ☐ **NO**

TREATMENT / RECOMMENDATIONS

☐ Physiotherapy / Occupational Therapy **Start date:** **Frequency:**	☐ Chiropractor **Start date:** **Frequency:**	☐ Splint **Removal date:**
☐ Cast **Removal date:**	☐ Angioplasty **Date:**	☐ Psychotherapy **Start date:** **Frequency:**
☐ Radio Therapy **Frequency:** **Duration:**	☐ Chemotherapy **Type:** _____ **Frequency:** **Duration:**	☐ Other

PLEASE LIST ALL MEDICATIONS RELATED TO CURRENT ILLNESS:

Generic or Trade name	Dose (i.e. 75 mg, bid)	Start/Change Date	Response (good, poor, none)
1.			
2.			
3.			
4.			

FUNCTIONAL ABILITIES:

Please check clearly what level of activity your patient is able to perform, as applicable to diagnosis/condition:

Please note: The Company has a Modified Return to Work Program and will seek to accommodate employees who are unable to perform their normal job duties.

ABILITY:

STAND ☐ 15 MIN ☐ 30 MIN ☐ 60 MIN ☐ NO LIMITATION ☐ OTHER

WALK ☐ SHORT DISTANCES ONLY ☐ NO LIMITATION ☐ TOTALLY UNABLE TO WALK

SIT ☐ 15 MIN ☐ 30 MIN ☐ 60 MIN ☐ NO LIMITATION ☐ OTHER

LIFT/CARRY: FLOOR - WAIST

☐ LESS THAN 5 KG (11 LBS) ☐ LESS THAN 10 KG (22 LBS) ☐ LESS THAN 20 KG (44 LBS) ☐ OTHER

LIFT/CARRY: WAIST - SHOULDER

☐ LESS THAN 5 KG (11 LBS) ☐ LESS THAN 10 KG (22 LBS) ☐ LESS THAN 20 KG (44 LBS) ☐ OTHER

LIFT/CARRY: ABOVE SHOULDER

☐ LESS THAN 5 KG (11 LBS) ☐ LESS THAN 10 KG (22 LBS) ☐ LESS THAN 20 KG (44 LBS) ☐ OTHER

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FUNCTIONAL ABILITIES (Continued):

CLIMB STAIRS	☐ 2 -3 STEPS	☐ SHORT FLIGHT	☐ OWN PACE	☐ AS TOLERATED
CLIMB LADDER	☐ 2 -3 STEPS	☐ OWN PACE	☐ AS TOLERATED	
LIMITED ABILITY TO USE HAND TO:		☐ HOLD OBJECTS	☐ GRIP	☐ TYPE AT KEYBOARD
		☐ WRITE	☐ FINE MANIPULATION	

PHYSICAL ABILITY	PARTIALLY REDUCED		TOTALLY REDUCED		
Operate mechanical equipment	☐		☐		Consecutive hrs
Operate motor vehicle	☐		☐		Consecutive hrs
Bend / twist: neck	☐		☐		
Bend / twist: back	☐		☐		
Push / pull	☐		☐		Kg/ Lb/
Reach: below shoulder	☐ L	☐ R	☐ L	☐ R	Consecutive hrs
Reach: above shoulder	☐ L	☐ R	☐ L	☐ R	Consecutive hrs
Sight	☐ L	☐ R	☐ L	☐ R	
Hearing	☐ L	☐ R	☐ L	☐ R	
Speech	☐		☐		
Balance	☐		☐		
Concentration	☐		☐		

COGNITIVE/PSYCHOLOGICAL ABILITY FOR THE JOB	PARTIALLY REDUCED	TOTALLY REDUCED
Socialization (i.e. relate to other people, supervision/ management, teamwork)	☐	☐
Concentration/Focus (i.e. perform simple and repetitive tasks, attention to detail, organization, multi-tasking)	☐	☐
Decision Making & Judgment (i.e. perform complex and varied tasks, analyze safety risks)	☐	☐
Energy/Vigour	☐	☐
Learning Memory	☐	☐

Observations or comments supporting the above:

CURRENT TREATMENT PLAN – Please describe

RETURN TO WORK

Is complete recovery expected?	☐ Yes ☐ No ☐ Unknown
Accommodations:	☐ Reduced hours – **please provide details**
	☐ Modified duties as above

P.S. Kindly include a copy of your clinical notes, consult reports and any consultations/investigations pertinent and relevant from the first treatment date for the condition claimed to the date the form is completed.

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CLINICAL NOTES FROM RECENT VISITS INCLUDED ☐ Yes ☐ No

ADDITIONAL COMMENTS:

Date of next consultation: _____

_____ _____

PHYSICIAN SIGNATURE **DATE**

_____ _____ _____

PHYSICIAN'S NAME – Please Print **TELEPHONE** **LICENSE NUMBER**