Long-Term Disability Income Benefit

Employee's Statement

Great-West Life

THE
Great-West Life
ASSURANCE COMPANY

Employee's Statement
Long Term Disability Income Benefits

This guide explains how to apply for Long Term Disability benefits. It contains the form you must complete to notify Great-West Life of your claim, and explains what will happen after you have submitted that notice.

Your employer will tell you which Great-West Life Disability Management Services Office has been assigned to assess your claim. Your notice form, and any other correspondence about your claim, should be submitted to your employer or to that office.

If you have any questions about your claim, a representative in your Disability Management Services Office will be happy to answer them.

Notice of Claim, Authorization and Physician's Statement

To begin the claim submission process, you should complete the notice of claim and authorization form included in this guide. In addition, please have your doctor complete the physician's statement. These forms should be submitted **at least 8 weeks** before the end of the Waiting Period. **Benefits may be delayed if these forms are submitted later than this.**

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 Plan Number**.

Note: If you have Guaranteed Standard Issue Program coverage with Great-West Life, this form will be used as notice of claim for that coverage as well.

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 the form that is most appropriate to your claimed condition. If you have undergone any tests or seen any specialists, please ensure that your physician includes copies of the results and the reports.

Claim Interview

To begin the detailed assessment process, a Great-West Life representative may telephone you to obtain information about your job, education and employment history, medical history, and current disability. Information may be required about certain other sources of income that could affect the amount of your benefit.

If an interview is not possible because of medical or language problems, alternative arrangements will be made. If sufficient information is obtained through the claim forms, an interview may not be necessary.

Income Declaration

You will be sent a form asking you to sign a declaration concerning other income to which you may be entitled.

Once you have signed the income declaration, please return the form to Great-West Life. This completes your part in submitting your claim.

Employer's Statement

When your employer gives you this brochure, he/she will submit an employer's statement to Great-West Life. This statement confirms your effective date of insurance coverage, job information, monthly earnings, and other information that is needed to assess your claim.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits, and this includes responsibility for providing medical reports. However, to simplify the application process for you and prevent delays, Great-West Life will provide you with any needed medical questionnaires for your physician to complete.

If additional medical information is required, Great-West Life will make every effort to obtain it as quickly as possible. You will be notified if no response has been received within 4 weeks of our request to your physician. You will also be asked to follow-up with your Physician to ensure timely completion of medical questionnaires.

Your physician may or may not request a fee for completing claim reports (including the attached statement). If they do, you are responsible for paying it. Whenever Great-West Life requests information directly from your doctor, a correspondence fee will be offered.

Claim Assessment

Once the employer's statement, your signed Income Declaration form, and medical records have been received, your claim will be promptly and thoroughly assessed by a Case Manager.

Benefit Approval

If your claim is accepted according to the terms of your group disability plan, Great-West Life will send you a summary of both the benefits that have been approved and any additional benefits that may be available to you. Any limitations which may apply to your claim will also be explained.

Your benefit cheque will be issued on the later of:

1. the date which is one month after your waiting period ends; and
2. the date on which the initial claim assessment is completed.

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**.

☐ 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. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (maximum 12 digits)
BRANCH ADDRESS	NAME IN WHICH ACCOUNT IS HELD		
CITY OR TOWN & PROVINCE / POSTAL CODE			

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

SIGNATURE OF EMPLOYEE

DATE

THE
Great-West Life
ASSURANCE COMPANY

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 (______) ______________________

   Cell (______) ______________________

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 _____________

Employer Information

1. Your Employer's Name: ______________________________________

   Address: Street & Number ______________________________________

   City ______________________ Province __________________ Postal Code ____________

   Telephone Number: (______) ______________________

2. Group Plan Number ______________________________________

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

Interview Arrangements

1. Please indicate if there are any times or dates when a telephone interview about your claim would be most convenient for you. (Please note that it may be determined that a telephone interview is not required.)

   ____

2. If a telephone interview is not possible, please explain why.

   ____

3. In which official language do you wish us to communicate with you? ☐ English ☐ French

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. Have you had this condition before? ☐ Yes ☐ No
   If yes, please elaborate ____

Medical Treatment

1. Name and address of the Physician currently supervising your treatment.
   Name: ______________________ Address: ______________________
   ____

2. Names and addresses of other physicians who have treated you for this condition.
   Name: ______________________ Address: ______________________
   ____
   Dates: From ______________________ To ______________________
   Name: ______________________ Address: ______________________
   ____
   Dates: From ______________________ To ______________________

3. Were you confined to hospital? ______________ If yes, complete the following:
   Hospital Name: ______________________ Address: ______________________
   ____
   Dates: From ______________________ To ______________________
   Hospital Name: ______________________ Address: ______________________
   ____
   Dates: From ______________________ To ______________________

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	☐	☐	☐	☐	$ __________ per month
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ __________ per week
Employment Insurance Benefits	☐	☐	☐	☐	$ __________ per week
Automobile Insurance Benefits	☐	☐	☐	☐	$ __________ per week/month
Any other Disability Benefits	☐	☐	☐	☐	$ __________ per week/month
Employer Sponsored Retirement/Pension Income	☐	☐	☐	☐	$ __________ per week/month
Self Employment or any other Employment Income			☐	☐	$ __________ per week/month
Any other Income	☐	☐	☐	☐	$ __________ per week/month

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 INITIAL BENEFIT STATEMENTS.

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.

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.

Print Name	Signature
Date	Telephone Number

THE
Great-West Life
ASSURANCE COMPANY

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

The patient is responsible for any fees related to the completion of this form.

General Form

Attending Physician's Statement - Long Term Disability Claim

Section 1	**Plan Member/Employee Information and Consent** **TO BE COMPLETED BY THE PATIENT**

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female | Home Phone # (+ Area Code) | Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name | Group Plan Number | GWL Employee Identification Number | Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy) | **Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy)

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: ____________

Weight: ____________

Dominant Hand:

Left ☐ Right ☐

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/Employee Signature Date of Consent (dd/mm/yyyy)

Section 2	**Attending Physician's Statement** **TO BE COMPLETED BY THE DOCTOR**

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) ______________________

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: ______________________________

Secondary and/or Complications: ______________________________

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy)

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Is this condition due to: Occupational Illness/injury Yes ☐ No ☐	Auto Accident Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy) ______	If yes, date of event: (dd/mm/yyyy) ______

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) ______

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) ______	First date of work absence due to condition: (dd/mm/yyyy) ______

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

______

______

______

______

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) ______

Date of last visit: (dd/mm/yyyy) ______

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

If yes, date: (dd/mm/yyyy) ______ Treatment provider: ______

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: ______

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: ______

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

Investigations

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**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

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

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Functional Abilities

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

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Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) ______________________ Type of licence: ______________________

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐ Please elaborate:

____

____

____

____

____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

____

____

____

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

____

____

____

____

____

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)	
Signature	Date Signed (dd/mm/yyyy)	

THE **Great-West Life** ASSURANCE COMPANY

INITIAL ATTENDING PHYSICIAN'S STATEMENT LONG TERM DISABILITY INCOME BENEFITS

Psychiatric Form

TO BE COMPLETED BY YOUR PSYCHIATRIST

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL.**

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ________________________ Date of birth: Year ________ Month ________ Day ________

Address: Street & Number ____

City ________________________ Province ____________ Postal Code ____________

Telephone Number (including area code): (______) ________________________

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.

Patient's Signature ____ Date ________________

Part 2: Attending Psychiatrist's Statement

1. **Diagnosis (please use DSM IV Criteria)**

Supporting Data
Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.

Axis I ________________________ ____

________________________ ____

________________________ ____

Axis II ________________________ ____

________________________ ____

Axis III ________________________ ____

________________________ ____

Axis IV ________________________ ____

Axis V Current GAF Score ____________

Highest GAF Score in Past Year ____________

Lowest GAF Score in Past Year ____________

2. **History (please provide copies of all relevant clinical notes and consultation reports on file.)**

When did symptoms start and/or worsen? Year ________ Month ____________ Day ________

Date patient's condition first prevented them from working? Year ________ Month ____________ Day ________

Date of first visit for treatment or consultation Year ________ Month ____________ Day ________

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: ____

Were work problems a factor in the development of your patient's disorder? ☐ Yes ☐ No

If yes, please specify. ____

Has a claim been filed with the Workers' Compensation Board? ☐ Yes ☐ No

Date of latest visit: Year ________ Month ____________ Day ________

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______

Are patient's symptoms due to drug or alcohol abuse? ☐ Yes ☐ No

If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility ______

Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when ______

Treatment for Psychiatric / Psychological Illness

Treatment Dates	For What Condition?	Treatment Provider or Facility (name, address, clinical specialty)

Date of hospital inpatient admission: Year ______ Month ______ Day ______

Date of discharge: Year ______ Month ______ Day ______

Date of hospital outpatient admission: Year ______ Month ______ Day ______

Name of hospital: ______

3. **Precipitating and complicating factors**

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

☐ Workplace issues ☐ Social / Family Issues ☐ Physical / Mental Condition ☐ Financial / Legal Problems

☐ Coping Skills ☐ Alcohol / Drug Abuse ☐ Personality / Motivation ☐ Other Issues

Comments: ______

4. **Current treatment**

Therapy method: ______

Therapy goal: ______

Frequency and length of therapy / counselling sessions: ______

Number of therapy / counselling sessions to date: ______

Treatment compliance: ______

Treatment response to date: ______

Prognosis and time-frame of illness: ______

Medications: Medication Name				
Date Started (y/m/d)				
Initial Dosage				
Initial Response				
Date of Last Dosage Change (y/m/d)				
Current Dosage				
Response				
Side Effects				
Compliance				
Date Medication Discontinued (y/m/d)				

Future Treatment Plans

What changes in your treatment plan are underway or are being considered? ______________________________

____

____

____

5. **Return to work plans**

Prognosis for recovery: ____

Expected date patient will return to their own occupation: Year __________ Month ____________ Day ________

If unknown, please indicate the next follow up date: Year __________ Month ____________ Day ________

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) ______________________________

____

Is your patient a suitable candidate for vocational rehab? ☐ Yes ☐ No

If yes, please specify: ____

____

When and under what circumstances could patient return to **other** work? (eg. modified duties, gradual return to work)

____

____

____

____

6. **Comments**

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

____

____

____

____

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

INITIAL ATTENDING PHYSICIAN'S STATEMENT LONG TERM DISABILITY INCOME BENEFITS

TO BE COMPLETED BY YOUR SPECIALIST

Musculo-Skeletal Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL.**

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ___________________ Date of birth: Year _________ Month __________ Day _________

Address: Street & Number ____

City ______________________ Province ______________ Postal Code ______________

Telephone Number (including area code): (______) ______________________________

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.

Patient's Signature ____ Date ______________

Part 2: Attending Physician's Statement

1. **Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports)**

Primary: ____

Secondary: ____

Date symptoms first appeared Year __________ Month ____________ Day ________

Date patient's condition first prevented them from working Year __________ Month ____________ Day ________

Date of first visit for treatment or consultation Year __________ Month ____________ Day ________

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: ____

Is condition a result of an injury due to an accident? ☐ Yes ☐ No

If yes, please describe. ____

Current height ______________ Current weight ______________ Weight loss / gain to date ______________

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

If yes, have Workers' Compensation Board/CSST forms been completed? ☐ Yes ☐ No

Date of latest visit: Year __________ Month ____________ Day ________

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______________________________

Date of hospital inpatient admission: Year __________ Month ____________ Day ________

Date of discharge: Year __________ Month ____________ Day ________

Date of hospital outpatient admission: Year __________ Month ____________ Day ________

Name of hospital: ____

Other treating physicians: ____

Pending referrals to specialists: ____

2. Please outline all objective studies performed / scheduled (X-rays, laboratory data, C.T. scans, etc.) and **attach copies of each report.**

Date	Procedure	Results

3. Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If Arthritic Condition: ☐ In Remission ☐ Continuously Active ☐ Stable ☐ Seasonally Active ☐ Intermittently Active ☐ Progressive

If Fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. **Treatment**

Medications (dose / frequency / date prescribed): ____________________

Physiotherapy (type, frequency, dates): ____________________

Surgery date (past): Year ________ Month ________ Day ______ Type: ____________________

Surgery date (future): Year ________ Month ________ Day ______ Type: ____________________

Other treatment: ____________________

Is patient compliant with prescribed measures? ☐ Yes ☐ No If No, please explain: ____________________

5. **Limitations and Restrictions**

		Hours at one time					Total hours during day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
☐ No restriction	☐ Repetitively - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please indicate in the space provided if this patient is able to perform the following actions:
(Frequently (F), Occasionally (O) or Not at all (N):)

Drive ____ Bend ____ Squat ____ Kneel ____ Climb ____ Reach (above shoulders) ____ Reach (below shoulders) ____

6. **Prognosis / Return to work plans:**

Prognosis for recovery: ____________________

Expected date patient will return to their own occupation: Year ________ Month ________ Day ________

If unknown, please indicate the next follow up date: Year ________ Month ________ Day ________

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work). ____________________

____

Assessment and treatment are complicated by: (please select and explain in the space provided below)

☐ Significant emotional or behavioral disorder such as depression, anxiety, etc.

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

☐ Work-related issues (please describe if known) ____________________

☐ Substance abuse ____________________

☐ Other (please describe) ____________________

____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: ____________________

____

7. **Comments**

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

____

____

____

____

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

INITIAL ATTENDING PHYSICIAN'S STATEMENT LONG TERM DISABILITY INCOME BENEFITS

TO BE COMPLETED BY YOUR CARDIOLOGIST

Cardiac Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL.**

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ______________________ Date of birth: Year ________ Month __________ Day ________

Address: Street & Number ______________________________________

City ______________________ Province ____________ Postal Code ______________

Telephone Number (including area code): (______) ____________________________

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.

Patient's Signature ______________________________________ Date ________________

Part 2: Attending Cardiologist's Statement

1. **Diagnosis** (please provide copies of all relevant clinical notes, test results and consultation reports on file)

   Primary: ______________________________________

   Secondary: ______________________________________

   Date symptoms first appeared Year __________ Month __________ Day __________

   Date of first visit Year __________ Month __________ Day __________

   Date patient's condition first prevented them from working: Year __________ Month __________ Day __________

   Date of latest visit: Year __________ Month __________ Day __________

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______________________

   Date of hospital inpatient admission: Year __________ Month __________ Day __________

   Date of discharge: Year __________ Month __________ Day __________

   Date of hospital outpatient admission: Year __________ Month __________ Day __________

   Name of hospital: ______________________________________

   Subjective symptoms (including severity/frequency/duration): ______________________

2. **Findings**

   ☐ Chest pain of cardiac origin ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia

   ☐ Psychophysiologic ☐ Other (please specify): ______________________

   BP readings over last 6 months (including dates) ______________________

   Current height ____________ Current weight __________ Weight loss/gain to date ____________

   Current status? ☐ Stable ☐ Improving ☐ Regressing

3. **Laboratory tests** (completed/scheduled) - please include copies of relevant test results.

EKG Year ___________ Month ______________ Day ________

Echocardiogram Year ___________ Month ______________ Day ________

Stress Thallium Test Year ___________ Month ______________ Day ________

Pulmonary Function Test Year ___________ Month ______________ Day ________

Blood Test Year ___________ Month ______________ Day ________

X-rays Year ___________ Month ______________ Day ________

Angiogram Year ___________ Month ______________ Day ________

4. **Treatment**

Medications (dose / frequency / date prescribed): ________________________________

Other treatment (please describe): ________________________________

Surgery date (past): Year ___________ Month ______________ Day ________ Type: ________________

Surgery date (future): Year ___________ Month ______________ Day ________ Type: ________________

Other treating physicians: ________________________________

Is patient compliant with prescribed treatment? ☐ Yes ☐ No If No, please explain: ________________

____

Has your patient been enrolled in a cardiac rehab program? ☐ Yes ☐ No

If yes, provide details: ________________________________

____

5. **Restrictions and limitations**

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

	Weight	Frequency	Duration	What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?
Lifting/Carrying	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			
Pushing/Pulling	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			How does this affect the patient's ability to perform activities of daily living?
Standing Walking Driver's license revoked?	__________ hours __________ blocks ☐ Yes ☐ No			

6. **Return to work plans:**

Prognosis for recovery: ________________________________

Expected date patient will return to their own occupation: Year ___________ Month ______________ Day ________

If unknown, please indicate the next follow up date: Year ___________ Month ______________ Day ________

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) ________________________________

Assessment and treatment are complicated by: (please select and explain in the space provided below)

☐ Significant emotional or behavioral disorder such as depression, anxiety, etc.

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

☐ Work-related issues (please describe if known) ______________________________

☐ Substance abuse ______________________________

☐ Other (please describe) ______________________________

____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)?

☐ Yes ☐ No

Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: ______________________________

7. **Comments**

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

____

____

____

____

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

INITIAL ATTENDING PHYSICIAN'S STATEMENT LONG TERM DISABILITY INCOME BENEFITS

Cancer Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): __________________________________ Date of birth: Year _________ Month __________ Day ________

Address: Street & Number ____

City ______________________________________ Province _________________ Postal Code ___________________

Telephone Number (including area code): (______) ____

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.

Patient's Signature ____ Date _________________________

Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). **Please attach a copy of all consultation, operative and pathology reports.**

   Date of cancer diagnosis: Year __________ Month ______________ Day ________

   Site of the tumor: ____

   Type of tumor: ____

   Histology and staging: ____

2. **History**

   Date symptoms first appeared: Year __________ Month ______________ Day ________

   Has patient ever had the same or similar condition? ☐ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment. ____

   ____

   Describe current symptoms: ____

   First visit for these symptoms: Year __________ Month ______________ Day ________

3. Current Height: __________________ Current Weight: ________________ Weight loss/gain to date: _________________

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year ___________ Month ______________ Day ________

5. **Treatment**

   Date of first visit: Year __________ Month ______________ Day ________

   Date of latest visit: Year __________ Month ______________ Day ________

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

   If other, please specify ____

   Treatment: Include information on all treatments to date and future treatment plan, inclusive of:

   Surgery: ____

   Radiation: ____

   Hormones: ____

   Chemotherapy: ____

6. **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: ____

7. Describe response to therapies to date: ☐ N/A ☐ partial ☐ Complete

Describe all comorbid conditions: ____

Describe any "post therapy"sequelae: ____

Prognosis: ____

8. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

9. 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.

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 ________

10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

____

____

11. 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 ______________________________

www.greatwestlife.com

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