THE Great-West Life ASSURANCE COMPANY

Application for Group Long Term Disability Benefits - Employer's Statement

Important:

The completed Employer's and Employee's Statements are required before claim assessment can commence. These forms should be submitted to Great-West Life at least 8 weeks prior to the end of the Elimination Period. **Benefits may be delayed if these forms are submitted later than 8 weeks prior to the end of the Elimination Period.** Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee. **Ensure all sections and both pages are completed as lack of information will cause delays in claim assessment.**

A. EMPLOYER IDENTIFICATION

Name	Plan Number	Division Number (if applicable)	Class (if applicable)

Address: Street & Number PO Box	City	Province	Postal code

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth

Address: Street & Number PO Box	City	Province	Postal Code

Telephone Number	Cell Number	Fax Number

C. EMPLOYMENT INFORMATION

Effective date of hire MM/DD/YY _____ Date last worked MM/DD/YY _____ Number of hours _____

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Work related accident or sickness ☐ Quit ☐ Retired ☐ Other ☐ Temporary Lay-off ☐ Paid Vacation

Is the employee: ☐ Full time: Number of hours worked per week _____ ☐ Part time: Number of hours worked per week _____

Is the employee: ☐ Permanent ☐ Temporary ☐ Seasonal ☐ Contract

Is the employee: ☐ Hourly ☐ Salaried ☐ Commissioned

Please submit copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If no, is a return to work date known?	Has employment terminated?
☐ Yes _____ MM/DD/YY ☐ No	☐ Yes _____ MM/DD/YY ☐ No	☐ Yes _____ MM/DD/YY ☐ No

D. INSURANCE INFORMATION

Date employee became insured under the Long Term Disability Plan. MM/DD/YY	Was the Employee a late applicant? ☐ Yes ☐ No	Effective date of excess insurance, if applicable: MM/DD/YY

Is the employee covered for Guaranteed Standard Issue Program Insurance with Great-West Life? ☐ Yes _____ Plan Number ☐ No

E. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

Employee's Gross monthly earnings $ _____ per month	Average monthly commissions earned in the 24 months ending on the last day worked:	TD-1 Federal personal tax credits:	For Quebec residents, tax deductions according to the latest TP-1015.3:

Date earnings ceased or will cease: MM/DD/YY	According to your records: Basic LTD Benefit Amount	Excess LTD Benefit Amount	Is the employee covered for Group Life Insurance? ☐ Yes _____ Plan number $ _____ Amount ☐ No Is the employee covered for Optional Life Insurance? ☐ Yes _____ Plan number $ _____ Amount ☐ No

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☐ Yes ☐ No

If yes, percentage of employment income that is tax exempt: _____ %

If the employee has Optional Life Insurance, please submit a copy of the Optional Life approval letter.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Name (please print): _____ Date: _____

Title: _____ Phone: _____

Email address: _____ Fax: _____

Authorized Signature: _____

If submitting form by fax or mail, the **Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.

THE REMAINDER OF THIS SUBMISSION IS TO BE COMPLETED BY THE EMPLOYEE'S IMMEDIATE SUPERVISOR OR FOREMAN

F. DISABILITY / REHABILITATION

When did the employee's disability first appear to affect his/her work? MM/DD/YY

In what ways did performance on the job change as a result of the disability?

Were any changes made in the employee's job duties as a result of the disability? ☐ Yes ☐ No

If yes, please explain what the changes were and when they were made:

If the employee could return to work part-time or less demanding work, would such work be available? ☐ Yes ☐ No

If no, please explain:

G. JOB INFORMATION – if a detailed job description has been provided, please disregard this section.

Employee's job title as of last day worked

How long has the employee worked in this position? Years Months

What are the duties in this job, and what percentage of time does each take per week?

Duties	Percentage of time per week

Work Environment: Does the employee's job require work in any of the following conditions?

	YES	NO	% of TIME
outside?	☐	☐	
in extreme cold or heat?	☐	☐	
in a damp or humid environment?	☐	☐	
in a noisy environment?	☐	☐	
in a dusty or unventilated environment?	☐	☐	
in toxic fumes?	☐	☐	

Does the job involve handling chemicals? If so, please list:

When completing the sections regarding "Strength" and "Mobility", please check the space that appropriately describes the **percentage of time** that the employee is engaged in the task during the course of their **normal** routine.

Strength: Does the job require the employee to lift or carry:

	N/A	1-25%	25-50%	50-75%	75-100%
up to 50 lbs / 22.7 Kg?	☐	☐	☐	☐	☐
up to 20 lbs / 9.1 Kg?	☐	☐	☐	☐	☐
up to 10 lbs / 4.5 Kg?	☐	☐	☐	☐	☐

Communication: How much of the employee's time is spent:

talking? _____ %

writing? _____ %

supervising other people? _____ %

Mobility: Does the job involve:

	N/A	1-25%	25-50%	50-75%	75-100%
walking?	☐	☐	☐	☐	☐
climbing?	☐	☐	☐	☐	☐
driving: Daytime?	☐	☐	☐	☐	☐
Nightime?	☐	☐	☐	☐	☐
reaching: above shoulder height?	☐	☐	☐	☐	☐
at shoulder height?	☐	☐	☐	☐	☐
below shoulder height?	☐	☐	☐	☐	☐
bending or crouching?	☐	☐	☐	☐	☐
kneeling or crawling?	☐	☐	☐	☐	☐

Endurance: Please check the time frame which most accurately reflects the amount of time the employee is required to maintain the following activities before changing position or activity.

	Sitting at	Standing at	Driving at
0 - 30 minutes	☐	☐	☐
30 - 60 minutes	☐	☐	☐
60 - 90 minutes	☐	☐	☐
more than 90 minutes	☐	☐	☐

Please specify the total hours that would be spent in an average day:

	Sitting	Standing	Driving
0 - 2 hours	☐	☐	☐
2 - 4 hours	☐	☐	☐
4 - 6 hours	☐	☐	☐
6 - 8 hours	☐	☐	☐

Equipment Use: Please list any office machines, tools, or other equipment that the employee uses in this job. You may provide your response in terms of the number of times the equipment is used per day or the percentage of time spent using the equipment, whichever is more applicable.

Type of Equipment	Times / Day	Percentage of Time

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Name (please print): _____ Date: _____

Title: _____ Phone: _____

Email address: _____ Fax: _____

Supervisor or Authorized Signature: _____

If submitting form by fax or mail, the **Supervisor or Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.

Clear