

**Long Term
Disability
Income
Benefit**

Employee's Guide

THE
Great-West Life
ASSURANCE  COMPANY

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.

Employee's Statement, Authorization and Physician's Statement

To begin the claim submission process, you should complete the Employee's Statement and authorization request 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. Employee's Statement

The Employee's Statement 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**.

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.

NOTICE OF CLAIM

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.

Identification

1. Mr. Mrs. Ms.

Your Name: First _____ Initial _____ Last _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone: Home (____) _____ confidential Work (____) _____ confidential

Cell (____) _____ confidential

If you wish us to leave a detailed message with personal information about your claim at a number, check the box marked "confidential" beside that number. Otherwise, we will only leave a general message with callback information at that number.

Email address: _____

If you would like Great-West Life to communicate with you by email about your disability claim, please fill in your email address. Emails Great-West Life sends to this address will be sent securely using Proofpoint Secure Email.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per month
Workers' Compensation Board Benefits (or similar plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week
Employment Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week
Automobile Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week/month
Any other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week/month
Employer Sponsored Retirement/Pension Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week/month
Self Employment or any other Employment Income			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per week/month
Any other Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ 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.

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.**

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.

TRANSIT#	INSTITUTION#	ACCOUNT#
TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

NAME OF BANK, TRUST CO, CREDIT UNION, ETC.

DATE

SIGNATURE OF EMPLOYEE

Application for Disability Income Benefits Employee's Authorization Request

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.

Group Plan Number

GWL Employee Identification Number

Print Employee Name

Employee Signature

Date

Telephone Number

The patient is responsible for any fees related to the completion of this 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) <input type="checkbox"/> Male <input type="checkbox"/> 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: <table border="0" style="width: 100%;"> <thead> <tr> <th style="width: 30%;">Name of Medication</th> <th style="width: 20%;">Dosage (mg)</th> <th style="width: 20%;">How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Please provide your: Height: _____ Weight: _____ Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?																			
1. _____	_____	_____																			
2. _____	_____	_____																			
3. _____	_____	_____																			
4. _____	_____	_____																			
5. _____	_____	_____																			
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 <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (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) _____																					

Is this condition due to: Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____	Auto Accident Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/> (describe) _____ Date of last visit: (dd/mm/yyyy) _____	
Has the patient been treated for this same or similar condition in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date: (dd/mm/yyyy) _____ Treatment provider: _____	
Is the patient following the recommended treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> Please elaborate: _____	
Response to Treatment	
Please describe the response to treatment to date: Complete <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> Too soon to tell <input type="checkbox"/>	
Are there any plans to change or augment the current treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please explain: _____	
Hospitalization	
Is/was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> Is future hospitalization planned? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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:

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)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	



Attending Physician's Statement

Section A	Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT		
Plan Member/Employee Name (Last, First, Middle Initial) <input type="checkbox"/> Male <input type="checkbox"/> 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, if known (dd/mm/yyyy) _____		Please provide your: Height: _____ Weight: _____
<p>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.</p> <p>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.</p> <p>I understand that I am responsible for any fees related to the completion of this form.</p> <p>I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.</p>			
Plan Member/Employee Signature _____		Date of Consent (dd/mm/yyyy) _____	
Section B	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR		
I am the: Attending Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____			
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE			
1. Diagnosis			
Primary: _____			
Secondary: _____			
Is this condition related to: Occupational Illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> If so, date of event: (dd/mm/yyyy) _____			
Details: _____			
Date of first visit to you pertaining to this condition (dd/mm/yyyy) _____		First date of work absence due to this condition: (dd/mm/yyyy) _____	
Has the patient been treated for this same or similar condition in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, date: (dd/mm/yyyy) _____ By whom: _____			
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____			

2. Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: _____

3. Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy / Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration / Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect / Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight / Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Observations or comments supporting the above: _____

4. Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

- Workplace Issues Social / Family Issues Financial / Legal Problems
- Physical Condition Alcohol / Drug Abuse Medication Side Effects
- Pain Perception Coping Skills Personality / Motivation Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

5. 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 / consultations pending? Yes No Date report expected: (dd/mm/yyyy) _____

Does the patient have an appointment booked with an specialist(s) in the near future? Yes No

Name of Specialist _____ Specialty _____ Date of Appointment: (dd/mm/yyyy) _____

1. _____

2. _____

Reason for requesting the consultation: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes No Don't know

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

6. Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7. Hospitalization

Is/was the patient hospitalized? Yes No Is future hospitalization anticipated? Yes No

Date admitted (dd/mm/yyyy) _____ Date discharged (dd/mm/yyyy) _____ Institution Name _____

1. _____

2. _____

8. Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

9. Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

10. Overall Response to Treatment

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

Is the patient following the recommended treatment program? Yes No

Please explain: _____

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

If so, please explain: _____

11. Prognosis and Recovery

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

Please provide the patient's prognosis for improvement: _____

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

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.

Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address		Telephone # (+ Area Code)
Email Address		Fax # (+ Area Code)
Signature or Stamp		

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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Spasm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Atrophy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Tendon Reflexes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Change		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Deficit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straight Leg Raising Limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of Motion Limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk on uneven surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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+
<input type="checkbox"/> No restriction	<input type="checkbox"/> Repetitively - how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Occasionally - how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Email Address: _____

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

Physician's signature _____ Date _____

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 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

Psychophysilogic 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	_____ hours			
Walking	_____ blocks			
Driver's license revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Email Address: _____

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

Physician's signature _____ Date _____

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: _____

Email Address: _____

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

Physician's signature _____ Date _____



www.greatwestlife.com