# A Guide to Claiming Disability Benefits

# and

# Application for Long Term Disability Benefits

For everything you ever wanted to know about Group Benefits go to
www.cooperators.ca/life/group

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LC 211

# *A Guide to Claiming Disability Benefits*

***(Please keep this section for your reference.)***

***Applying for disability benefits can be confusing. This brochure is designed to assist you in this process and to provide answers to the most commonly asked questions.***

### *How do I qualify for disability benefits?*

Disability benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury and are paid to you until such time as you can return to work.

To qualify for benefits you must be an eligible covered employee, meet the definition of total disability in your group insurance policy, complete an elimination period, and otherwise satisfy the group insurance policy terms.

Your application for disability benefits does not automatically entitle you to be paid benefits, for reasons that will be stated later in this booklet.

### *What happens after I submit my claim for disability benefits?*

Your claim will be reviewed as quickly as possible.
We confirm that you are an eligible covered employee by confirming that:

- you are enrolled in the group insurance plan;
- premiums have been paid; and
- you were actively at work before you became disabled.

Once coverage is confirmed we review information submitted to determine whether you are totally disabled as defined in your group policy of insurance. The information that we review includes medical documentation and a description of your job duties.

Your claim will be delayed if insufficient information is provided. In this case we will write to inform you of the delay and we may also ask you to help us obtain more information.

Once your claim is approved, a cheque and letter will be mailed either to you or to your employer. If your claim is denied, we will write to you and explain the reason(s) for the denial.

### *Will my personal information have privacy protection?*

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business. The Co-operators will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding. The Co-operators privacy policies, please refer to your Employee Booklet or our website, www.cooperators.ca/life/group.

### *What information does Co-operators Life Insurance Company require to make the claims adjudication decision and what can I do to avoid delays?*

1. Make sure all forms are fully completed.
2. Provide additional details of all factors, both at work and at home, which affect your ability to be at work.
3. Ask your employer to provide your physician and us with your most recent job description and task analysis on each job function.
4. Ask your doctor to include reports from all specialists, results of all testing, and any other medical information. If we do not receive sufficient, clear information, we may be required to write to your physician to obtain the information, resulting in a delay of your claim.
5. Provide copies of CPP/QPP, WCB/WSIB and auto insurance claim records if you have applied for or are receiving any of these benefits.

### *Why would my claim be denied?*

Your claim will be denied if you are not eligible for the coverage, where we determine that the medical evidence does not support that you are totally disabled, or you do not otherwise qualify for benefits under the group insurance policy.

Research has shown that it is possible and advantageous for people to remain at work while in active treatment for certain medical conditions and that such an approach can actually shorten the recovery period.

Time taken off work due to the pressure and tension that you may experience in your workplace, as the result of such factors as difficult relationships with co-workers, increased workloads and job demands, actions taken by employers in good faith, such as discipline, work evaluation, transfer, lay-off, demotion or termination are generally regarded as a normal part of the work situation and not as a basis for “total disability” (ie. unable to work due to illness or injury).

### *Why would I be requested to submit additional medical information once my claim has been approved?*

We require periodic updates on your condition and evidence of continuing total disability. In order to obtain this evidence we may send forms for you and your doctor to complete. In some cases, we may write directly to your physician.

The frequency of these requests will depend upon the nature of your condition and the definition of total disability in your group policy.

### *Rehabilitation and a Safe Return to work.*

If your claim is approved, we may contact you to discuss your return to work. Everyone benefits from your safe and timely return to work. If appropriate, our rehabilitation case manager will work with you, your employer and your physicians to determine and develop the appropriate return to work plan designed just for you.

### *When should I apply for Canada Pension Plan/Quebec Pension Plan (CPP/QPP) disability benefits?*

Your plan administrator/employer may have already asked you to apply. If not, we will advise you when it is time for you to apply. In most group insurance policies, CPP/QPP benefits must be deducted from disability benefits. Benefits received from CPP/QPP are taxable. Your group disability benefit will be reduced by the before-tax CPP/QPP benefit, whether your group disability benefit is taxable or nontaxable. If you qualify for CPP/QPP benefits, please send us a copy of your Notice of Entitlement so we can recalculate your benefit amount. If we have overpaid you, you will need to pay us back.

If your claim for CPP/QPP benefits has been denied, we may ask you to appeal that decision or to reapply.

### *What if I have applied for Workers Compensation (WCB/WSIB) benefits?*

You must still submit your completed insurance claim forms and any other supporting documents to your employer at the same time as you would have, had you not applied to WCB/WSIB. This ensures your claim form is received by us within sufficient time, in the event your Workers Compensation application is denied or benefits are discontinued.

In most policies, WCB/WSIB benefits must be deducted from disability benefits. If you qualify for WCB/WSIB benefits, please notify our office so we can recalculate your benefit amount. If we have overpaid you, you will need to pay us back.

### *Do I pay premiums while I am receiving WCB/WSIB benefits?*

If you are receiving WCB/WSIB benefits, you may also be able to have your group insurance premiums waived for some or all of your coverages even if you do not receive disability benefits from Co-operators Life Insurance Company.

For information about premium payments when you are receiving WCB/WSIB benefits, please refer to your employee booklet.

### *How do I claim for Long Term Disability (LTD) benefits?*

If your elimination period is 60 days or less and you expect to be off work long enough to be eligible for disability benefits, you, your employer and doctor must complete an Application for Long Term Disability benefits soon after you stop working.

To give us time to review the information submitted before your first benefit payment is due, return the following to your employer SIX to EIGHT weeks BEFORE the end of your elimination period:

1) Application for Long Term Disability Benefits - Employee Statement.
   - complete BOTH sides in as much detail as possible.
2) Proof of age (Birth or Baptismal Certificate or Passport) if age 60 or over.
3) Attending Physician's Initial Disability Benefits Statement *
   - complete the section "Patient's Authorization to Release Information", then give the form to your doctor to complete.

   ***Note*** - your doctor may send the completed physician's statement and any other information which supports your claim directly to Co-operators Life Insurance Company or give you the completed form etc. to send to us.

   Example of other information which supports your claim:
   1. test results (blood work, x-rays, CT scans, psychological testing etc);
   2. your doctor's office notes;
   3. specialists' consultation reports; and
   4. hospital admission and discharge summaries, and operative reports.

* Except where prohibited by law, you are responsible for paying any fees your doctor charges for completion of forms or for providing medical reports.

Your employer will complete and send the Employer's Statement which gives information about your earnings, benefit coverage and job duties. You can expect to hear from us approximately twenty days after we receive your claim forms.

### *How and when will I receive my LTD benefit payments?*

In most cases benefits are payable after you have completed the elimination period.

Long Term Disability (LTD) benefits are paid once a month. The cheques are mailed either to you directly or to your employer, as decided by your policyholder. Our standard practice is to mail your cheque to your employer. This insures you are in-touch with your workplace and makes your return to work easier for you.

Payment of LTD benefits will cease when:

1. the medical evidence received indicates you are no longer totally disabled;
2. you have recovered sufficiently to allow you to safely return to work; or
3. until you have reached the maximum benefit period payable stated in your group insurance policy.

*NOTE:* You may be eligible to receive an adjusted (rehabilitation) benefit if initially you need to return to work on a part-time basis.

### *Do I pay premiums while I am receiving LTD benefits?*

For information about premium payments when you are receiving LTD disability benefits, please refer to your employee booklets.

### *Further questions I may have.*

If you have any questions or if you need help with your LTD claim, please contact your plan administrator or our claims office in Regina at 1-800-667-8164. Please have your group policy and PID ready to assist us with your inquiry.

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1920 College Avenue, Regina SK S4P 1C4

# APPLICATION FOR LONG TERM DISABILITY BENEFITS

## Employee Statement

**PLEASE PRINT**

**PLEASE COMPLETE AND SIGN THIS PORTION OF YOUR APPLICATION FOR LONG TERM DISABILITY BENEFITS AND RETURN THIS FORM PROMPTLY.**
**NOTE: YOUR SIGNATURE IS ALSO REQUIRED ON THE ATTENDING PHYSICIAN'S STATEMENT.**

**IMPORTANT: Failure to fully answer all questions will delay the processing of your claim.**

| Policy/Plan No. | Account No. | S.I.N. ___ — ___ — ___ | ❒ Long Term Disability ❒ Waiver Group Life Insurance Premium (if applicable) |
|---|---|---|---|

❒ Mr. ❒ Mrs.
❒ Miss ❒ Ms.

last name | first name

| Date of birth Day Month Year | If age 60 or over, enclose copy of **birth certificate.** | Height | Weight | Sex ❒ Male ❒ Female | Telephone number |
|---|---|---|---|---|---|

Address

No. & Street | Suite/Apt. No. | City/Town | Province | Postal Code

| Your Plan Sponsor/ Employer | Occupation | Employer's Telephone Number |
|---|---|---|

Address

No. & Street | Suite/Apt. No. | City/Town | Province | Postal Code

Describe your present medical condition, its cause and history. If you were injured, also describe accident, including date, time and where it took place

| Date symptoms began Day Month Year | Date of first treatment for this illness/injury Day Month Year | Medical condition has prevented me from working since Day Month Year |
|---|---|---|

Have you ever had a similar injury or illness in the past? ❒ Yes ❒ No If "Yes", describe your condition, the original date of illness or injury, and any time lost from work.

If your condition is the result of an injury or motor vehicle accident, please describe the events surrounding the accident:

a) Was another party at fault? ❒ Yes ❒ No
b) Was alcohol involved in the events surrounding the accident? ❒ Yes ❒ No
c) Was it reported to the police? ❒ Yes ❒ No (If yes, attach a copy of police report.)
d) Were any charges laid? ❒ Yes ❒ No (If yes, against whom?)
e) Are you pursuing a claim for wage loss against a third party? ❒ Yes ❒ No (If no, please give reasons)

List all physicians you have seen for your present medical condition (**Attach copies of all available specialists' reports.**)

| Physician's Name | Address | Dates Seen From | Dates Seen To | Dates of Any Hospitalization From | Dates of Any Hospitalization To | Next Appointment Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Has your doctor told you to restrict your activities in any way? ❒ Yes ❒ No If "Yes", state what he/she told you about restricting your activities.

Employee Name: _____

Have you discussed a return to work with your employer? ❒ Yes If "Yes", have you discussed a return to work at:

Own Occupation ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year **OR**

New Job/Duties ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year

Have you discussed a return to work with your physician? ❒ Yes If "Yes", have you discussed a return to work at:

Own Occupation ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year **OR**

New Job/Duties ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year

❒ No If "No", please explain:

**OTHER INCOME**

Have you applied for or are you receiving any other disability, wage loss, and/or retirement benefits? ❒ Yes ❒ No If "Yes", complete this section.

❒ WCB Amount_____ Frequency _____ Effective _____ Claim No. _____

❒ CPP/QPP Amount_____ Frequency _____ Effective _____ Claim No. _____

❒ Car Insurance Amount_____ Frequency _____ Effective _____ Claim No. _____

❒ EIC Amount_____ Frequency _____ Effective _____ Claim No. _____

Other (e.g. legal action, retirement pension, creditor insurance, mortgage insurance, etc.) _____

**NOTE: ATTACH COPIES OF ALL CORRESPONDENCE YOU HAVE RECEIVED, RELATED TO THE ABOVE MATTER.**

**PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS**

## Summary of Claimant's Education, Training and Experience

**(PLEASE PRINT)**

Note: This information is important to the assessment and administration of your claim. **Please complete in full. (Attach a separate sheet if necessary.)**

| **EDUCATION/TRAINING** | |
|---|---|
| Indicate the highest grade level of education completed: | ❒ Grade 6 or under ❒ 7 ❒ 8 ❒ 9 ❒ 10 ❒ 11 ❒ 12 ❒ 13 |
| Name of technical or trade school attended: | |
| Type of diploma obtained: | |
| Name of college or university: | |
| Number of years completed: | |
| Type of degree obtained: | |
| Other training, special or vocational courses: | |
| | |
| | |
| | |
| | |
| | |

Employee Name: _____

## WORK EXPERIENCE

**Present Employment:** Briefly describe your duties and when you started in this job:

**Previous Employment:** Please complete the following, providing details of your **previous** positions.

| Employer | Job Title and Duties | Duration of Employment | |
|---|---|---|---|
| | | From | To |
| | | | |
| | | | |
| | | | |
| | | | |

**Job Skills:** What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc.) Where appropriate, give level of proficiency.

**Community Interests:** Outline your past or present involvement with any community/church/volunteer organizations

**Hobbies:**

### Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

### AUTHORIZATION AND ASSIGNMENT

In consideration for any payment of disability benefits made to me by Co-operators, the policyholder or plan administrator (the"payor"), I hereby agree to refund, in accordance with the provisions of the policy/plan document, from any source as defined under All Source Benefit and/or Other Income, any monies that may be due to the payor, and further irrevocably assign all right, title and interest of such monies and any group life insurance proceeds to the payor for such purpose. I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator or their agents, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person or organization having any medical, employment, vocational, financial or other relevant personal information or records regarding me to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to investigate and confirm the accuracy and validity of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

I understand that my refusal or withdrawal of consent may delay claims adjudication or result in denial of my claim. I declare that the information provided in this Employee Statement and any statements provided in any personal or telephone interview relating to this claim are/will be true, complete and accurate.

This authorization shall remain valid for the duration of the claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

_____ _____

Employee Signature Date

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1920 College Avenue, Regina SK S4P 1C4

# ATTENDING PHYSICIAN'S INITIAL DISABILITY BENEFITS STATEMENT

## PATIENT'S AUTHORIZATION TO RELEASE INFORMATION

Patient's Name_____ Age_____ Policy/Plan No._____

I hereby authorize the release to the Plan Administrator and/or Plan Adjudicator and my Insurer of any information requested in respect of this claim. **Note: The patient is responsible for obtaining this form and for any charges for its completion except in those provinces where prohibited by statutory regulations.**

Date _____Signature of patient _____

ATTENDING PHYSICIAN'S STATEMENT

TO PHYSICIANS - PLEASE NOTE:
This form has been specifically designed with the Physician in mind. By being comprehensive, it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and stroke out non-applicable areas. In order to help the claimant, sufficient details of history, investigation, findings and treatment are essential. Your patient is reponsible for the cost of completing this form, except in those provinces where prohibited by statutory regulations. This form may be mailed directly to Co-operators Life Insurance Company at 1920 College Avenue, Regina, Saskatchewan S4P 1C4, or given to the patient at the physicians discretion. Please attach copies of Chart Notes, Test results and Consultation reports.

**HISTORY**

| | |
|---|---|
| Date symptoms first appeared or accident occurred. Day Month Year | Date patient ceased work because of current condition Day Month Year |
| Date of first visit for present condition: Day Month Year | Since first visit, how often have you seen this patient? ❒ Weekly ❒ Bi-weekly ❒ Monthly |
| | Date of next visit _____ Date of last visit _____ |
| Has patient ever had same or similar condition? ❒ Yes ❒ No ❒ Unknown If "Yes", what precipitated absence from work? | Is condition due to injury or sickness arising out of patient's employment? ❒ Yes ❒ No ❒ Unknown |
| Is condition considered chronic? ❒ Yes ❒ No If "Yes", what precipitated absence from work? | |

Has your patient been referred to any other physician/specialist? ❒ Yes ❒ No If "Yes", complete the following chart.

| Physician's/Specialist's Name | Specialty | Dates of Examinations |
|---|---|---|
| | | |
| | | |

Summarize physician's/specialist's findings.

Blood Pressure (last visit) _____Weight _____Height _____

**DIAGNOSIS:**

Primary

Other factors which may affect the duration of this disability: ❒ Addictions ❒ Dietary ❒ Psychosocial ❒ Family ❒ Employment ❒ General Fitness ❒ Pre-Existing Condition(s) ❒ Other medical conditions ❒ Environmental factors ❒ Other

The claimant previously had the same or similar condition. ❒ Yes ❒ No
Please explain any of the above.

Subjective symptoms.

Objective findings.

| **Investigations** (e.g. EKG's, x-rays, lab tests, etc.) | **Date Carried Out** | **Summary of Results (Attach copies of all available reports.)** |
|---|---|---|
| | | |
| | | |

Are any further investigations planned? ❒ Yes ❒ No If "Yes", state type and when.

If condition is due to pregnancy, please give expected date of confinement. Day Month Year

**PHYSICAL CAPABILITIES:**

What activities is the patient capable of doing on a regular basis?

Are you aware of the duties of your patient's job?

What restrictions prevent the patient from performing the duties of their job?

Patient's Name: _____

**DISORDERS OF NECK OR BACK: EXAMINATION OF ❒ Neck ❒ Back**

| **A. Range of Motion** | Normal (C = cervical) C | T | L | Pain (T = thoracic) C | T | L | Limitation (L = lumbar) C | T | L |
|---|---|---|---|---|---|---|---|---|---|
| Flexion | __. | __. | __. | __. | __. | __. | __. | __. | __. |
| Extension | __. | __. | __. | __. | __. | __. | __. | __. | __. |
| Right rotation | __. | __. | __. | __. | __. | __. | __. | __. | __. |
| Left rotation | __. | __. | __. | __. | __. | __. | __. | __. | __. |
| Rt. Lat. flexion | __. | __. | __. | __. | __. | __. | __. | __. | __. |
| Left Lat. flexion | __. | __. | __. | __. | __. | __. | __. | __. | __. |

**B. Palpatory Tenderness?** ❒ Yes ❒ No

| If yes: | Left | Midline | Right |
|---|---|---|---|
| Cervical spine | . | . | . |
| Thoracic spine | . | . | . |
| Lumbar spine | . | . | . |
| C. Straight leg raising limited? | ❒ Yes | ❒ No | |
| D. Other findings | . | . | . |

**E. Neurological Examination**

❒ Normal

If not, specify:

| **Sensory deficit** | | **Motor weakness** | | **Decreased deep tendon reflexes** | |
|---|---|---|---|---|---|
| *Right* | *Left* | *Right* | *Left* | *Right* | *Left* |
| Arm ❒ | Arm ❒ | Arm ❒ | Arm ❒ | Arm ❒ | Arm ❒ |
| Leg ❒ | Leg ❒ | Leg ❒ | Leg ❒ | Leg ❒ | Leg ❒ |

**Diagnostic tests:**

Plain radiographs ❒ none indicated ❒ Normal

Degenerative changes at level(s) _____.

Fracture/dislocation at level(s) _____.

Other radiographic findings: _____.

**Diagnosis: Whiplash associated disorder**

❒ Grade I (c/o neck pain and stiffness but no objective findings)

❒ Grade II (neck complaints with musculoskeletal signs such as decreased ROM &/or tenderness)

❒ Grade III (neck symptoms with neurological signs e.g. decreased tendon reflexes, muscular weakness and sensory deficit)

❒ Grade IV (neck symptoms with fracture and/or dislocation)

Other diagnostic tests shown

**Low back injury:**

❒ Grade I (c/o pain and stiffness but no objective findings)

❒ Grade II (back symptoms with musculoskeletal signs such as decreased ROM &/or tenderness)

❒ Grade III (back symptoms with neurological signs e.g. decreased tendon reflexes, muscular weakness and sensory deficit)

❒ Grade IV (back symptoms with fracture and/or dislocation)

**PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS**

**PSYCHOLOGICAL CAPABILITIES**

What is your patient's diagnosis according to the DSM-IV?

Axis I _____ Axis II _____ Axis III _____ Axis IV _____ GAF - Current Date _____ GAF - Past Date _____

What psychometric testing has been performed? **Attach copies of all psychometric testing results, chart notes, treatment notes, and medical records.**

**Psychiatric Degrees of Impairment**

❒ No Impairment (Functioning is generally adequate or normal for this claimant in any work setting)

❒ Impairment Only in the Work Setting (Functioning is generally adequate for this claimant outside of the work setting)

Reason:

Are you aware of the duties of your patient's job?

What major tasks of the patient's occupation is she/he able to perform?

Unable to perform? (List specifics that impair functional activity.)

❒ Impaired (for each category circle only one item)

❒ activities of daily living
1. some degree of difficulty encountered
2. several everyday activities cannot be carried out without assistance or support. (basic personal care still unassisted).
3. needs assistance with most routine daily activities. Significantly neglects personal care.
4. requires substantial help with all activities of daily living.

❒ social functioning
1. social interactions minimally disrupted
2. easily upset or somewhat guarded (interaction minimal outside family/close friends)
3. markedly withdrawn or uncommunicative even with immediate family. Overt hostility, obviously suspicious.
4. uncommunicative or communicates in bizarre or unpredictably hostile manner

❒ concentration & pace
1. task/functions performed adequately but with some degree of slowness or degree of agitation.
2. relatively routine tasks performed with difficulty and effort. Obvious/notable slowness and agitation.
3. incapable of sustaining attention on moderately complex tasks. Memory function is obviously impaired.
4. unable to sustain attention for even simple tasks, disoriented, memory is severly impaired.

❒ coping
1. coping is adequate but reacts to stress with some degree of anxiety or agitation.
2. obvious difficulty applying usual coping skills, stresses reacted to with considerable anxiety or agitation.
3. marked distress or anxiety to stress. Needs help coping with most complex or novel situations.
4. extreme agitation, panic or marked regression in response to stress, or, exhibits persistent hallucinations or delusions.

Has there been a psychiatric referral? ❒ Yes ❒ No If "No", please explain reasons.

Remarks:

Patient's Name: _____

**CARDIAC** (if applicable)

**Please forward results of exercise stress tests, angiogram, or other relevant documentation.**

| Based on the above assessment, the patient has: | **Physical** | **Psychological** | **Cardiac** |
|---|---|---|---|
| No limitation of functional capacity | ❒ | ❒ | ❒ |
| Slight limitation of functional capacity | ❒ | ❒ | ❒ |
| Moderate limitation of functional capacity | ❒ | ❒ | ❒ |
| Marked limitation of functional capacity | ❒ | ❒ | ❒ |
| Severe limitation of functional capacity | ❒ | ❒ | ❒ |

**VISUAL IMPAIRMENT** (if applicable)

| What was vision at latest observation? | | O.D. | O.S. |
|---|---|---|---|
| | With glasses | | |
| | Without glasses | | |

Vision can be restored in whole or in part by:

❒ O.D. ❒ Lenses ❒ Treatment ❒ Operation ❒ Not restorable

❒ O.S. ❒ Lenses ❒ Treatment ❒ Operation ❒ Not restorable

**MANAGEMENT PLAN FOR THE CURRENT DISABILITY**

A. No active treatment required _____.

B. **Treatments** (Specify in each instance)

❒ Medications ❒ Exercise ❒ Education ❒ Other Treatment

The medications might impair safety in the workplace for the claimant or others. ❒ Yes ❒ No (Specify)

| Name of Medication | Dosage | Dates Initiated | Reason For Change In Medication (if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Date of any hospitalizations:

| From | To |
|---|---|
| | |
| | |

Physiotherapy? ❒ Yes ❒ No If "Yes", frequency ❒ Daily ❒ 3 x per Week ❒ Weekly

❒ Other _____

Surgery? ❒ Yes ❒ No If "Yes", type of surgery _____

Date ❒ Performed ❒ Planned Day Month Year

Describe any other treatment or future plans. (Specify with dates)

Projected duration of treatment program:

Summarize patient's response to treatment:

Is patient following recommended treatment program? ❒ Yes ❒ No

**PROGNOSIS**

A. Activity Level

Is the patient currently: Working? ❒ Yes ❒ No Participating in activities of daily living? ❒ Yes ❒ No

Are there medical reasons for the person not to participate in normal activity including work? ❒ Yes ❒ No

If yes, describe:

The disability may affect activity for: _____# days if <8 ❒ 8-14 days. ❒ 15-21 days. _____# days if >21 days ❒ unknown

**Have you discussed a return to work with your patient?** ❒ Yes If "Yes", have you discussed a return to work at:

Own Occupation ❒ Full-time Date ❒ Part-time Date **OR**

New Job/Duties ❒ Full-time Date ❒ Part-time Date

❒ No If "No", please explain.

What is being done to return your patient to work?

If a modified work plan is presented to you, including hours of work, physical restriction, modifications, could you agree?

❒ Yes ❒ No

Please detail restrictions:

Next appointment: ❒ None Scheduled.

Comments:

Patient's Name: _____

**REHABILITATION:**

| | |
|---|---|
| Is patient a suitable candidate for further medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)? ❒ Yes ❒ No If "Yes", specify. | |
| Would vocational counselling and/or retraining be recommended? ❒ Yes ❒ No | Is patient attending a vocational assessment program? ❒ Yes ❒ No |

| |
|---|
| Remarks - Please provide comments and further details which you feel would be helpful. |

| | | |
|---|---|---|
| Physician's Name (Print) | Specialty | Fax Number ___ ___ ___ — ___ ___ ___ ___ |
| Address | | Telephone Number ___ ___ ___ — ___ ___ ___ ___ |
| Signature | Family Physician ❒ Yes ❒ No | Date |

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1920 College Avenue, Regina SK S4P 1C4

# APPLICATION FOR LONG TERM DISABILITY BENEFITS

## Employer's Statement

**PLEASE PRINT**

**Note:** Please certify current employment status and Long Term Disability coverage by completing and signing this portion of the application. If the employee appears to be entitled to Canada/Quebec Pension Plan Disability Benefits, have the employee submit an application.

| Policy/ Plan No. | Account No. | S.I.N. | ❒ Long Term Disability | ❒ Waiver Group Life Insurance Premium (if applicable) |
|---|---|---|---|---|

❒ Mr. ❒ Mrs.
❒ Miss ❒ Ms.

last name first name

**CLAIMANT INFORMATION:**

Date of Birth Day Month Year

If age 60 or over, copy of birth certificate must be enclosed with claimant's statement.

Sex ❒ Male ❒ Female

Telephone Number

Address

No. & Street Suite/Apt. No. City/Town Province Postal Code

Occupation: (State occupation held just before stopping work)
1. Is the employee currently absent for medical reasons? ❒ Yes ❒ No
2. If the employee is absent for another reason (e.g., maternity leave, leave of absence), please give details.

Is condition due to injury or illness arising out of employment? ❒ Yes ❒ No
If "Yes" has the employee applied for Worker's Compensation Benefits? ❒ Yes ❒ No If "No", please provide details:

**NOTE: If illness/injury is claimed to be work related, the employee must make application to the Worker's Compensation Board for benefits.**

**COVERAGE INFORMATION:**

Date of employment: Day Month Year

Date employee became ***insured*** under:
The Co-operators LTD policy _____ DD MM YY
With a previous carrier's LTD policy _____ DD MM YY

If employment now terminated, please indicate effective date: Day Month Year

Date last worked: Day Month Year

Date expected to return to work: Day Month Year

Date returned to work: Day Month Year

Class/Group/Union affiliation to which claimant belongs (if applicable) _____

❒ Salaried ❒ Hourly ❒ Full-time ❒ Part-time ❒ Contract (please enclose a copy of the contract agreement) Average hours worked per week _____(excluding overtime)
❒ Temporary ❒ Commissioned Is the employee involved in shift work? ❒ Yes ❒ No (If yes, what is the rotation schedule?)

**Please enclose copy of enrollment card.**

**EARNINGS/BENEFIT INFORMATION:**

State employee's pay schedule: ❒ Hourly ❒ Weekly ❒ Bi-weekly ❒ Monthly ❒ Annually Work Week i.e. Mon. - Fri._____

State rate of earned gross income immediately before stopping work, based on above pay schedule $_____ (exclude overtime, commissions and bonuses)

Date above rate became effective Day Month Year

State payroll deduction immediately before stopping work, based on above pay schedule *** Please attach copy of paystub for last full pay period. ***

Income Tax $_____ QPP/CPP $_____ EIC $_____ Pension (if applicable) $_____ RRSP (if applicable) $_____

Is any portion of the LTD premium paid for by the policyholder/employer? ____Yes (taxable) ____No (non taxable)

Current tax exemption per Federal TD1: $_____ (attach TD1).

On what date did (or will) the employee's salary end? Day Month Year

Does the employee currently receive remuneration from you? ❒ Yes ❒ No (If yes answer a & b below)

a. How much? $ Per hour Does this amount include unused sick leave? ❒ Yes ❒ No

b. Until what date will remuneration continue (including sick leave credits)? Day Month Year

**For commissioned or self employed provide T4, notice of assessment, and statement of expenses for previous two years.**

Employee Name: _____

**OTHER INCOME:**

| | | | |
|---|---|---|---|
| ❒ Sick pay<br>from Day Month Year<br>to Day Month Year | ❒ Weekly Indemnity<br>from Day Month Year<br>to Day Month Year<br>Paid by (name source)_____ | ❒ Worker's Compensation<br>from Day Month Year<br>to Day Month Year<br>Status _____ | ❒ EIC<br>from Day Month Year<br>to Day Month Year<br>Status_____ |

❒ CPP ❒ QPP Date applied Day Month Year Status _____

**PENSION INFORMATION** (if applicable)

At the date of disability, was the employee a member of one of the following plans? ❒ Yes ❒ No

❒ Defined Benefit Pension Plan ❒ Defined Contribution Pension Plan ❒ Group RRSP ❒ Individual RRSP

Administered by (name and address): (i.e. financial institution or organization)

_____

_____

Note: If contributions made to Group or Individual RRSP, please provide copy of Locked-In Agreement.

Date employee became or will become eligible to contribute: Day Month Year

Plan Name _____ Registration/Account Number _____

Contribution levels at date of disability Employee _____% Employer_____%

Total contributions made to the Plan this year Employee _____$ Employer_____$

## INFORMATION ABOUT THE DISABILITY AND REHABILITATION(attach extra sheets if necessary)

When did the employee's illness or injury first appear to affect his or her work? Day Month Year

From your observations did the employee's ability to perform their job change?

Were any changes made to the employee's job as a result of the illness or injury? ❒ Yes ❒ No (If yes give details)

What were the changes and when were they made?

If the employee could return to work part-time or with a change in duties, would a position be available? ❒ Yes ❒ No (If yes, give details)

Have you discussed a return to work with your employee? ❒ Yes If "Yes", have you discussed a return to work at:

Own Occupation ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year **OR**

New Job/Duties ❒ Full-time Date Day Month Year ❒ Part-time Date Day Month Year

❒ No If "No", please explain:

## RECENT JOB HISTORY

**GROUP POLICYHOLDER/EMPLOYER**

Please complete this form based on the claimant's job duties immediately before he/she stopped working

Position held:

Total number of hours worked per week (include regular overtime)

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

Please describe the duties of this job and what percentage of each work week is normally taken with each duty.

| Duties | Percentage of work week |
|---|---|
| | |
| | |

If the employee changed occupations or assignments during the 12 months immediately before the last day worked, describe the previous occupation or assignment, give the reason for the change and the effective date of the change.

Has this job been eliminated? ❒ Yes ❒ No Comments or additional information:

Employee Name: _____

**WORK ENVIRONMENT AND JOB ACTIVITIES (please provide a copy of the formal job description)**

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

| | | | | | |
|---|---|---|---|---|---|
| outside | ❒ Yes ❒ No | If yes, what percentage of time? | in a noisy environment | ❒ Yes ❒ No | If yes, what percentage of time? |
| in extremes of cold or heat | ❒ Yes ❒ No | If yes, what percentage of time? | in a dusty or unventilated environment | ❒ Yes ❒ No | If yes, what percentage of time? |
| in a damp or humid environment | ❒ Yes ❒ No | If yes, what percentage of time? | around toxic fumes | ❒ Yes ❒ No | If yes, what percentage of time? |

Does the employee's job involve handling chemicals? ❒ Yes ❒ No If yes, please list the chemicals below.

During the employee's normal routine, what percentage of time does the job require the employee to lift or carry the following weights?

| | Never | 1 to 25% | 25 to 50% | 50 to 75% | 75 to 100% |
|---|---|---|---|---|---|
| more than 50 lbs/22.7kg | ❒ | ❒ | ❒ | ❒ | ❒ |
| more than 20 lbs/9.1kg | ❒ | ❒ | ❒ | ❒ | ❒ |
| more than 10 lbs/4.5kg | ❒ | ❒ | ❒ | ❒ | ❒ |

During the employee's normal routine, what percentage of time does the job involve the following activities?

| | Never | 1 to 25% | 25 to 50% | 50 to 75% | 75 to 100% |
|---|---|---|---|---|---|
| walking | ❒ | ❒ | ❒ | ❒ | ❒ |
| stairs (How Many) | ❒ | ❒ | ❒ | ❒ | ❒ |
| ladder | ❒ | ❒ | ❒ | ❒ | ❒ |
| climbing | ❒ | ❒ | ❒ | ❒ | ❒ |
| driving: | | | | | |
| daytime | ❒ | ❒ | ❒ | ❒ | ❒ |
| night-time | ❒ | ❒ | ❒ | ❒ | ❒ |

| | Never | 1 to 25% | 25 to 50% | 50 to 75% | 75 to 100% |
|---|---|---|---|---|---|
| reaching: | | | | | |
| above shoulder height | ❒ | ❒ | ❒ | ❒ | ❒ |
| at shoulder height | ❒ | ❒ | ❒ | ❒ | ❒ |
| below shoulder height | ❒ | ❒ | ❒ | ❒ | ❒ |
| bending or crunching | ❒ | ❒ | ❒ | ❒ | ❒ |
| kneeling or crawling | ❒ | ❒ | ❒ | ❒ | ❒ |

How much time is the employee required to maintain the following activities before changing position?

| | 0 to 30 minutes | 30 to 60 minutes | 60 to 90 minutes | more than 90 minutes |
|---|---|---|---|---|
| sitting at one time | ❒ | ❒ | ❒ | ❒ |
| standing at one time | ❒ | ❒ | ❒ | ❒ |
| driving at one time | ❒ | ❒ | ❒ | ❒ |

During the average day, which is the number of hours the employee spends in the following positions or activities?

| | 0 to 2 hours | 2 to 4 hours | 4 to 6 hours | 6 to 8 hours |
|---|---|---|---|---|
| sitting | ❒ | ❒ | ❒ | ❒ |
| standing | ❒ | ❒ | ❒ | ❒ |
| driving | ❒ | ❒ | ❒ | ❒ |

What percentage of the employee's time is spent in the following activities?

| Talking | Writing | Supervising Other People |
|---|---|---|
| | | |

Please list any machines, tools, or other equipment that the employee uses in the job. You can either list the number of times per day the equipment is used or the percentage of time spent using the equipment, whichever is more applicable.

| Type of Equipment | No. of Times Per Day OR Percentage of time |
|---|---|
| | |
| | |
| | |

Please provide any additional information that may be relevant to this claim which has not been previously provided.

Name of Group Policyholder/Employer: _____

Address _____

_____

Form Completed by: Name & Title (Please Print) _____

Telephone Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Authorized Signature _____ ___ ___ ___ ___ ___ ___

Area Code Day Month Year

Supervisor's Name

Address _____

_____

Telephone Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Fax Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Area Code Area Code

Union Representative's Name

Address _____

_____

Telephone Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Fax Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Area Code Area Code