# Long-Term Disability Income Benefit

*Employee's Statement*

Great-West Life

*your Benefits Solutions People*

THE Great-West Life ASSURANCE COMPANY

# Employee's Statement
# Long Term Disability

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

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

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

## Notice of Claim, Authorization and Physician's Statement

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

### 1. Notice of Claim

The Notice of Claim asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your **Group Policy 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.

## DIRECT DEPOSIT AUTHORIZATION

Should your claim be accepted, you can have your benefit payments automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life. **All benefit payments covered under one policy number will be deposited into the same bank account**.

If you'd like to take advantage of Electronic Funds Transfer, please fill in the information below.

☐ Savings Account only, (please consult your bank for proper bank identification number)

☐ Chequing Account, (please attach sample cheque marked "VOID")

**PLEASE PRINT**

| | |
|---|---|
| NAME OF BANK, TRUST CO., CREDIT UNION, ETC. | TRANSIT NO. INSTITUTION NO. ACCOUNT NO. |
| BRANCH ADDRESS | NAME IN WHICH ACCOUNT IS HELD |
| CITY OR TOWN & PROVINCE POSTAL CODE | |

**NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY**

SIGNATURE OF EMPLOYEE _____ DATE _____

THE Great-West Life ASSURANCE COMPANY

## NOTICE OF CLAIM

### Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   P.O. Box _____

   City _____ Province _____ Postal Code _____

   Telephone: Home (_____) _____ Work (_____) _____

2. Your GWL Employee Identification Number _____

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

3. Social Insurance Number _____

   I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number only where required in the administration of my benefits.

   Employee's Signature _____

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 Policy Number _____

   Policy 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 | | |
|---|---|---|---|---|---|
| | Yes | No | Yes | No | Amount |
| Canada Pension Plan/Quebec Pension Plan Benefits | ☐ | ☐ | ☐ | ☐ | $ _____ per month |
| Workers' Compensation Board Benefits (or similar plan) | ☐ | ☐ | ☐ | ☐ | $ _____ per week |
| Employment Insurance Benefits | ☐ | ☐ | ☐ | ☐ | $ _____ per week |
| Automobile Insurance Benefits | ☐ | ☐ | ☐ | ☐ | $ _____ per week/month |
| Any other Disability Benefits | ☐ | ☐ | ☐ | ☐ | $ _____ per week/month |
| Employer Sponsored Retirement/Pension Income | ☐ | ☐ | ☐ | ☐ | $ _____ per week/month |
| Self Employment or any other Employment Income | | | ☐ | ☐ | $ _____ per week/month |
| Any other Income | ☐ | ☐ | ☐ | ☐ | $ _____ per week/month |

For the duration of your claim for benefits, it is your responsibility to notify Great-West Life of:

- any work performed, whether or not you have received a wage or remuneration, or
- any employment income paid to you or any other person or party as a result of work performed by you.

2. Do you have Individual Disability, Creditor or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes ☐ No If so, please provide your policy number: _____

**IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF INITIAL BENEFIT STATEMENTS.**

Date: _____ Signature: _____

**Protecting Your Personal Information**

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in 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 information in your files 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 information to investigate and assess your claim and to administer the group benefit plan.

## Authorizations and Declarations

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments;
- Great-West Life to exchange my information with my employer, plan sponsor, or plan administrator when relevant for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims.

Except for audit purposes, this authorization 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 Employee's Statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

Print Name _____ Signature _____

Date _____ Telephone Number _____

THE Great-West Life ASSURANCE COMPANY

# INITIAL ATTENDING PHYSICIAN'S STATEMENT - LONG TERM DISABILITY BENEFITS

General Form

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

**Instructions**:

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

POLICY 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 hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

Patient's Signature _____ Date _____

## Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). If psychiatric, give DSM-IV Code.

   Primary: _____

   _____

   Secondary: _____

   _____

   Subjective symptoms (including severity, frequency, duration): _____

   _____

   Findings **(please enclose a copy of current x-rays, EKGs, Laboratory Data)**: _____

   _____

2. **History (please attach a copy of your clinical notes relating to this period of disability)**

   Date symptoms first appeared or accident happened: Year _____ Month _____ Day _____

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

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

   If yes, please specify diagnosis and dates of treatment: _____

   _____

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

   Have Workers' Compensation/CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

   If patient is pregnant, give E.D.C. Year _____ Month _____ Day _____

   Names and specialties of other treating physicians. **(If available, please provide copies of all relevant consultation reports)**

   _____

   _____

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

3. **Treatment Dates**

   Date of first visit for current condition: Year _____ Month _____ Day _____

   Date of latest visit: Year _____ Month _____ Day _____

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

   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: _____

4. **Nature of Treatment**

Medications (dose, frequency, date prescribed) _____

_____

Surgeries (including dates) _____

_____

Other (including frequency) _____

_____

Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate) _____

_____

5. **Progress**

Has patient: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed

6. **Restrictions and limitations**

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

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

Drive____Bend____ Squat____ Kneel____ Climb____ Reach (above shoulders)____ Reach (below shoulders)____

7. **Mental / Nervous Impairment (if applicable)**

History: _____

Precipitating Chronological Events: _____

Are work related issues contributing to your patient's condition? _____

Relevant current dynamics _____

Changes in ADL habits _____

Familial risk factors _____

Progress with treatment plan _____

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

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

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

Do you believe patient is competent to endorse cheques and direct the use of the proceeds thereof? ☐ Yes ☐ No

If no, from what date? Year _____ Month _____ Day _____

Have you referred the case to the Public Trustee? ☐ Yes ☐ No

8. **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?) _____

_____

Other factors affecting a return to work: _____

9. **Rehabilitation**

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

☐ Yes ☐ No If yes, please specify: _____

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

If yes, please specify: _____

10. **Comments**

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

_____

_____

_____

---

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

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

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

# INITIAL ATTENDING PHYSICIAN'S STATEMENT - LONG TERM DISABILITY BENEFITS

**Psychiatric Form**

**TO BE COMPLETED BY YOUR PSYCHIATRIST**

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

**Instructions**:

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

POLICY 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 hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

Patient's Signature _____ Date _____

## Part 2: Attending Psychiatrist's Statement

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

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

Axis I _____ _____

_____ _____

_____ _____

Axis II _____ _____

_____ _____

Axis III _____ _____

_____ _____

Axis IV _____ _____

Axis V Current GAF Score _____

**Highest GAF Score in Past Year** _____

**Lowest GAF Score in Past Year** _____

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

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

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

Date of first visit for treatment or consultation Year _____ Month _____ Day _____

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

If yes, state when and describe: _____

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

If yes, please specify. _____

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

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____

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

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

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

**Treatment for Psychiatric / Psychological Illness**

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

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

Date of discharge: Year _____ Month _____ Day _____

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

Name of hospital: _____

3. **Precipitating and complicating factors**

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

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

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

Comments: _____

_____

4. **Current treatment**

Therapy method: _____

Therapy goal: _____

Frequency and length of therapy / counselling sessions: _____

Number of therapy / counselling sessions to date: _____

Treatment compliance: _____

Treatment response to date: _____

Prognosis and time-frame of illness: _____

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

**Future Treatment Plans**

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

_____

_____

5. **Return to work plans**

Prognosis for recovery: _____

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

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

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

_____

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

If yes, please specify: _____

_____

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

_____

_____

_____

6. **Competency**

Do you believe your patient is competent to endorse cheques and direct the use of the proceeds thereof? ☐ Yes ☐ No

If no, from what date? Year _____ Month _____ Day _____

Have you referred the case to the Public Trustee? ☐ Yes ☐ No

7. **Comments**

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

_____

_____

_____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

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

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

# INITIAL ATTENDING PHYSICIAN'S STATEMENT - LONG TERM DISABILITY BENEFITS

**TO BE COMPLETED BY YOUR SPECIALIST**

**Musculo-Skeletal Form**

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

**Instructions**:

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

POLICY 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 hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

Patient's Signature _____ Date _____

## Part 2: Attending Physician's Statement

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

Primary: _____

Secondary: _____

Date symptoms first appeared Year _____ Month _____ Day _____

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

Date of first visit for treatment or consultation Year _____ Month _____ Day _____

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

If yes, state when and describe: _____

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

If yes, please describe. _____

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

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

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

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____

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

Date of discharge: Year _____ Month _____ Day _____

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

Name of hospital: _____

Other treating physicians: _____

Pending referrals to specialists: _____

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

| Date | Procedure | Results |
|---|---|---|
| | | |
| | | |
| | | |

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

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

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

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

4. **Treatment**

Medications (dose / frequency / date prescribed): _____

Physiotherapy (type, frequency, dates): _____

Surgery date (past): Year _____ Month _____ Day _____ Type: _____

Surgery date (future): Year _____ Month _____ Day _____ Type: _____

Other treatment: _____

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

5. **Limitations and Restrictions**

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

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

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

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

Prognosis for recovery: _____

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

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

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

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

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

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

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

☐ Substance abuse _____

☐ Other (please describe) _____

_____

**Rehabilitation:**

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

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

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

_____

7. **Comments**

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

_____

_____

_____

_____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

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

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

# INITIAL ATTENDING PHYSICIAN'S STATEMENT - LONG TERM DISABILITY BENEFITS

**Cardiac Form**

**TO BE COMPLETED BY YOUR CARDIOLOGIST**

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.

POLICY 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 hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

Patient's Signature _____ Date _____

## Part 2: Attending Cardiologist's Statement

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

Primary: _____

Secondary: _____

Date symptoms first appeared Year _____ Month _____ Day _____

Date of first visit Year _____ Month _____ Day _____

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

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____

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

Date of discharge: Year _____ Month _____ Day _____

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

Name of hospital: _____

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

2. **Findings**

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

☐ Psychophysiologic ☐ Other (please specify): _____

BP readings over last 6 months (including dates) _____

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

Current status? ☐ Stable ☐ Improving ☐ Regressing

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

EKG Year _____ Month _____ Day _____

Echocardiogram Year _____ Month _____ Day _____

Stress Thallium Test Year _____ Month _____ Day _____

Pulmonary Function Test Year _____ Month _____ Day _____

Blood Test Year _____ Month _____ Day _____

X-rays Year _____ Month _____ Day _____

Angiogram Year _____ Month _____ Day _____

4. **Treatment**

Medications (dose / frequency / date prescribed): _____

Other treatment (please describe): _____

Surgery date (past): Year _____ Month _____ Day _____ Type: _____

Surgery date (future): Year _____ Month _____ Day _____ Type: _____

Other treating physicians: _____

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

_____

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

If yes, provide details: _____

5. **Restrictions and limitations**

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

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

| | Weight | Frequency | Duration | What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? |
|---|---|---|---|---|
| Lifting/Carrying | 1-10 lbs (0.5-4.5 kg)<br>11-20 lbs (5.0-9.1 kg)<br>21-50 lbs (9.5-22.7 kg) | | | |
| Pushing/Pulling | 1-10 lbs (0.5-4.5 kg)<br>11-20 lbs (5.0-9.1 kg)<br>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? ☐ Yes ☐ No | | | | |

6. **Return to work plans:**

Prognosis for recovery: _____

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

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

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

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

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

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

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

☐ Substance abuse _____

☐ Other (please describe) _____

_____

**Rehabilitation:**

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

☐ Yes ☐ No

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

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

7. **Comments**

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

_____

_____

_____

_____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

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

_____

Physician's signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

# INITIAL ATTENDING PHYSICIAN'S STATEMENT - LONG TERM DISABILITY BENEFITS

Cancer Form

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

**Instructions**:

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

POLICY 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 hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

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. Do you believe your patient is competent to endorse cheques and direct the use of the proceeds thereof? ☐ Yes ☐ No

    If no, from what date? Year _____ Month _____ Day _____

    Have you referred the case to the Public Trustee? ☐ Yes ☐ No

12. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

    _____

    _____

---

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

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

_____

Physician's signature _____ Date _____

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