

**Life
Waiver**

Employee's Statement

Great-West Life
your Benefits Solutions People



Employee's Statement Group Life Waiver of Premium Benefit

This guide contains the forms you need to apply for premium free continuance of your life insurance benefits and some important information about the claim process.

These forms should be submitted at least 8 weeks before the end of the Elimination Period. Your notice form, and any other correspondence you may wish to provide about your claim, should be submitted to the Great-West Life disability management services office assigned to assess your claim. Should you wish to submit your notice form directly to Great-West Life, please contact your employer for the appropriate mailing address.

1. Notice of Claim

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

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

2. Authorization Request

We need your permission to obtain information that will help us assess your claim. By signing this authorization request, you give Great-West Life permission to obtain this information from your doctor, your employer, other insurers and hospitals where you received treatment.

3. Attending Physician's Report

Ask your doctor to complete this form. It requests general information about your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance coverage began, your job duties and earnings. We have asked your employer to supply this information directly to us.

Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

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 _____

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.

Claim Information

1. What is the nature of your condition? _____

Please describe your daily routine since leaving work stating the tasks you are able to perform:

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

If work-related, have you filed a claim with the Workers' Compensation Board? Yes No

If yes, please provide Workers' Compensation Claim Number and contact phone number.

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 _____

Education / Training / Experience

High School Yes No Grade Completed _____

Course of Study: Academic Industrial Business Other _____

College Yes No Years completed _____ Degree _____ Major/Minor _____

Business / Trade School Yes No Years Completed _____

Degree or Certificate _____

Current Job Duties

What is your current job title: _____

What are the normal duties in this job, and how much time do they take each week?

DUTIES

HOURS PER WEEK

List all skills you have _____

Hobbies: _____

Do you expect to return to your regular job? Yes No Please explain why or why not _____

Are you able to do some parts of your regular work? Yes No Please explain: _____

Are you able to drive a car? Yes No Are you presently working? Yes No

Date employed: Year _____ Month _____ Day _____

Wages: _____ Part-time Self-employed Full Time Trial employment

Name and address of current employer _____

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 (WCB / WSIB) \$ _____ per week

Employment Insurance Benefits \$ _____ per week

Automobile Insurance Benefits \$ _____ per week/month

Any other Disability Benefits \$ _____ per week/month

Employer Sponsored Retirement / Pension Income \$ _____ per week/month

Self Employment or any other Employment Income \$ _____ per week/month

Any other Income \$ _____ per week/month

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

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

2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? Yes _____ Plan Number No

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

Date: _____ Signature: _____

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

Print Name

Signature

Date

Telephone Number

INITIAL ATTENDING PHYSICIAN'S STATEMENT GROUP LIFE WAIVER OF PREMIUM BENEFIT

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of Patient: _____ Employee Identification # _____

Name of Employer: _____ Plan Number _____

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.

Date: _____ Signature of Patient: _____

1. History

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

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

If yes, please specify diagnosis and dates of treatment _____

2. Diagnosis (including any complications)

Primary _____

Secondary _____

Subjective Symptoms: _____

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

3. Current Height _____ **Current Weight** _____

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

Year _____ Month _____ Day _____

5. Treatment

What is the current treatment regimen? (drug dosage, physio, other and progress)

Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

6. If condition is due to pregnancy, what is (or was) the expected date of confinement?

Year _____ Month _____ Day _____

7. 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

8. 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.

List physical restrictions and tolerances: _____

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 _____

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

10. **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: _____

11. **Surgery**

Surgical procedure performed: _____

Date of surgery: Year _____ Month _____ Day _____

Name of surgeon: _____

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 _____



www.greatwestlife.com

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