

**Important:**

The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed in its entirety and submitted to Great-West Life at least 8 weeks prior to the end of the elimination period.** Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee.

**Ensure all sections and both pages are completed as lack of information will cause delays in claim assessment.**

**A. EMPLOYER IDENTIFICATION**

Name		Plan Number	Division Number (if applicable)	Class (if applicable)
Address: Street & Number	P.O. Box	City	Province	Postal code

**B. EMPLOYEE IDENTIFICATION**

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth (MM/DD/YY)
Address: Street & Number	P.O. Box	City	Province	Postal Code	
Telephone Number			Fax Number		

**C. EMPLOYMENT INFORMATION**

Effective date of hire (MM/DD/YY) \_\_\_\_\_ Date last worked (MM/DD/YY) \_\_\_\_\_ Number of hours \_\_\_\_\_

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

Is the employee:  Full time: Number of hours worked per week \_\_\_\_\_  Part time: Number of hours worked per week \_\_\_\_\_

Is the employee:  Permanent  Temporary  Seasonal  Contract

Is the employee  Hourly  Salaried  Commissioned

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

Has employee returned to work? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No	If no, is a return to work date known? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No	Has employment terminated? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No
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**D. INSURANCE INFORMATION**

Date employee became insured for basic life insurance with GWL. (MM/DD/YY) _____	Was the employee a late applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Effective date of excess insurance, if any: (MM/DD/YY) _____	Date insurance or insurance premiums ended, if applicable: (MM/DD/YY) _____

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

**E. EARNINGS AND BENEFIT INFORMATION**

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

Amount of employee's Basic Life Insurance: \$ \_\_\_\_\_ Employee's annual earnings on date last reported for work: \$ \_\_\_\_\_

Does the employee have dependent Basic Life insurance under this same Great-West Life Group Plan Number?  
 Yes Please submit employee enrollment card and a copy of the LTD acceptance letter (if LTD benefits are provided by another carrier).  
 No

Is the employee covered for Optional Life Insurance with Great-West Life?  
 Yes Optional Life Plan Number: \_\_\_\_\_  
 Amount of employee's Optional Life Insurance \$ \_\_\_\_\_  
 No

Does the employee have dependent Optional Life Insurance coverage under this same Great-West Life Optional Life Plan Number?  
 Yes Please submit a copy of the Optional Life approval letter.  
 No

Date employee's earnings ceased or will cease: \_\_\_\_\_ (MM/DD/YY)

**DECLARATION**

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

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name (please print):** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**F. JOB INFORMATION**

Employee's job title as of last day worked

How long has the employee worked in this position?

Years

Months

**COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER.** If you have a prepared job description, please include it with the submission.

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

Duties

Percentage of time per week

_____	_____
_____	_____
_____	_____
_____	_____

To ensure proper management of this claim, more detailed job information may be requested at a later date.

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

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

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

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

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

If no, please explain.

**ADDITIONAL INFORMATION**

Please provide any additional information that you believe should be considered in assessing this employee's claim.

**DECLARATION**

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

Supervisor or Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_