Life Waiver

Employee's Guide

THE
Great-West Life
ASSURANCE COMPANY

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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. Employee's Statement

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

2. Authorization Request

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

3. Attending Physician's Report

Ask your doctor to complete 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.

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NOTICE OF CLAIM

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

Identification

1. Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   City _____ Province _____ Postal Code _____

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

   Cell (_____) _____ ☐ confidential

   Check the Confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

   Email address: _____

   Enter your email address if you would like Great-West Life to communicate with you by secure email about your disability claim.

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 _____

Your consent

Before we can process your claim for benefits, you must read this agreement and sign in the *signature* box below.

Sharing your personal information

We collect, use and disclose your personal information to:

- investigate and assess your claim
- administer your claim and the group benefits plan
- work out a rehabilitation plan to get you back to work
- audit the assessment of the claim.

We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Insurance and reinsurance companies
- Administrators of the plan, of government benefits and of other benefit programs
- Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
- Your employer's occupational health services
- Your union representative
- Service providers and other organizations working with us, or on behalf of the other parties mentioned above. We may use service providers outside Canada.
- An auditor authorized by us, your employer, plan sponsor or their agent

Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only persons with access to the information are:

- people working at Great-West Life and those we've authorized, who need the information to do their jobs and manage your claim
- those whom you've given access
- those authorized by law both within Canada and in any other jurisdiction where your personal information is held.

For a copy of our Privacy Guidelines see **greatwestlife.com** or you can write to Great-West Life's Chief Compliance Officer.

By signing below, you confirm that:

- You have read, understand and agree with the contents of this form and authorize us to collect and disclose your personal information.
- Except for audit purposes, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete
- A photocopy or electronic copy of this authorization is as valid as the original.

Your group plan number	Print your name	Date (mm/dd/yyyy)
Your Great-West ID number	Your signature X	Telephone number

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The patient is responsible for any fees related to the completion of this form.

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Attending Physician's Statement - Group Life Waiver of Premium Claim

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	GWL Employee Identification Number

Height	Weight	Date of Birth (dd/mm/yyyy)

Last Date Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

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

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

_____ _____

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: _____

Secondary and/or Complications: _____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐	Auto Accident Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy)	If yes, date of event: (dd/mm/yyyy)
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): _____ Date of discharge (dd/mm/yyyy): _____ Institution Name: _____

If surgery was performed please provide date and description of surgery:

Date (dd/mm/yyyy): _____ Description: _____

Treatment (drug, dosage, physiotherapy, other):

Prognosis Please provide the prognosis for recovery:

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Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date (dd/mm/yyyy): _____ Treatment Provider: _____

Please describe the patient's symptoms including history, severity and frequency:

_____

_____

_____

_____

_____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

Name of Specialist: _____ Specialty: _____ Date of Visit: _____

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities.

_____

_____

_____

_____

_____

_____

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

_____

_____

_____

_____

_____

_____

_____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

_____

_____

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

Clear

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