

The Employer's and Employee's Statements should be completed and sent to Great-West Life within 5 days of the onset of the disability. 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 are completed to prevent any delay in assessing this claim.

Company Name: _____ Plan Number: _____

EMPLOYEE IDENTIFICATION					
First Name	Middle Initial	Last Name	Great-West Life ID Number	Division	Class

Date of Birth (MM/DD/YY)	If plan is taxable provide Social Insurance Number	Home Phone Number	Cell Phone	Work Phone	

Home Address		City/Town	Province	Postal Code	

EMPLOYMENT INFORMATION	
Job title: _____	Effective date of hire: _____ (MM/DD/YY)
Employee's gross earnings prior to disability: _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
Complete every question in this section including a), b), and c).	
Employee is: a) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
b) <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Contract	
c) <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Commissioned <input type="checkbox"/> Salaried and Commissioned <input type="checkbox"/> Hourly and Commissioned	
<input type="checkbox"/> Other Description: _____	
Regular number of scheduled hours: _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	
Do the scheduled hours vary (excluding overtime)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the employee still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Date employment ended: _____ (MM/DD/YY)	

COVERAGE INFORMATION - When the employee enrolled and was added with coverage under this plan.	
Date the employee signed their enrollment form requesting to be added to the plan with group coverage: _____ (MM/DD/YY)	
The employee's coverage effective date. The date the employee was added to the plan with group coverage: _____ (MM/DD/YY)	
Basic disability coverage amount for the employee: _____ every week	
Does the employee have any excess STD insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Amount of excess STD insurance _____	

EMPLOYEE TAX INFORMATION	
TD-1 personal tax credits: _____	OR Quebec TP-1015.3 source deductions: _____
Is the employee exempt from tax under the Indian Act (CRA form TD1-1N)?	
<input type="checkbox"/> No	
<input type="checkbox"/> Yes What percent of the employee's income is tax exempt? _____ %	

EMPLOYEE TAX INFORMATION (con't)

The following must be completed if your plan is Administrative Services Only (ASO) AND you have authorized Great-West Life to deduct CPP/QPP and EI/QPIP from the employee on your behalf.

Employee's province of employment: _____

Enter the following amounts you deducted from your payroll system based on wages you paid:

Year-to-date CPP / QPP Contributions: _____ Year-to-date EI Premiums: _____ Year-to-date QPIP Premiums: _____

Year-to-date Pensionable Earnings: _____ Year-to-date Insurable Earnings: _____

ABSENCE INFORMATION

Employee's last day of work: _____ (MM/DD/YY) Percentage of day worked on last day _____ %

Employee's first day absent from work: _____ (MM/DD/YY)

Have you paid the employee beyond their last day of work?

No Yes Date employee paid to: _____ (MM/DD/YY) **OR** Ongoing

Type of pay: Sick Pay/Salary Continuance Vacations Days Other

What is the reason for the employee's absence from work? *Select all that apply:*

Medical

Strike

Temporary Lay-off Start date _____ (MM/DD/YY) Recall date (if known) _____ (MM/DD/YY)

Maternity Leave of Absence Start date _____ (MM/DD/YY) Planned end date _____ (MM/DD/YY)

Leave of Absence Start date _____ (MM/DD/YY) Planned end date _____ (MM/DD/YY)

Other _____

Is the absence due to a work related incident?

No Yes Has a worker's compensation claim been filed? No Yes

Has the employee returned to work?

No When do you expect the employee to return to work? _____ (MM/DD/YY) **OR** Unknown

Yes Date returned to work: _____ (MM/DD/YY)

The employee first returned to (*select all that apply*): Regular duties and hours Modified duties Modified hours

Were there any workplace issues leading up to the employee's absence? Yes No Unknown

Do you anticipate any difficulties with the employee's return to work? Yes No Unknown

Do you have any concerns with this employee's claim for disability benefits? Yes No Unknown

If yes or unknown to any of these questions, please explain. A Great-West Life claim representative may contact you to discuss further.

DECLARATION

I declare the information I've entered is accurate.

Today's Date (MM/DD/YY): _____

Name of Contact Person _____

Job Title _____

Phone Number _____

Email Address _____

Confidential Fax Number _____

Address _____

City/Town _____

Province _____

Postal Code _____

Authorized Signature: _____

If submitting form by fax or email, the Authorized Signature field must be signed.

If submitting form online, online certification will be applied.

EMPLOYEE IDENTIFICATION

First Name _____ Middle Initial _____ Last Name _____ Plan Number _____ Great-West Life ID Number _____

JOB INFORMATION - part 1

Employee's job title as of last day worked: _____

How would you classify the physical requirements of the employee's duties?

<input type="checkbox"/>	Limited	Work activities involve handling loads up to 5 kg. For example: • Examining and analyzing financial information. • Administering and marking written tests.
<input type="checkbox"/>	Light	Work activities involve handling loads up to 5 kg, but less than 10 kg. For example: • Repairing soles, heel and other parts of footwear. • Filing materials in drawers, cabinets and storage boxes. • Preparing and cooking meals.
<input type="checkbox"/>	Medium	Work activities involve handling loads between 10 kg, but less than 20 kg. For example: • Measuring, cutting and applying wallpaper to walls. • Adjusting, repairing or replacing mechanical or electrical components using hand tools and equipment.
<input type="checkbox"/>	Heavy	Work activities involve handling loads more than 20 kg. For example: • Shoveling cement into cement mixers and assisting in the maintenance and repair of roads. • Measuring, cutting and fitting drywall sheets for installation on walls and ceilings. • Operating power saws to thin and space trees in reforestation areas.

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

Did you make any changes to the employee's job duties prior to their absence as a result of their medical condition? Yes No

If yes, please explain:

JOB INFORMATION - part 2



You do not have to complete part 2 if the employee has returned to work or the absence will be less than 4 weeks.

Physical and Cognitive Demands

If you have documentation that outlines the physical and/or cognitive job demands you do not need to complete the section(s) below.

I will send a separate document outlining the: Physical job demands Cognitive job demands

Lifting/Carrying - Select the option that describes how often they are lifting/carrying during their normal work day

Weight	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
up to 100 lbs / 45 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 50 lbs / 22.75 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 20 lbs / 9.1 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
up to 10 lbs / 4.5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mobility - Select the option that describes how often they are performing each activity during their normal work day

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Endurance - Select the amount of time they are required to remain in an activity before changing to a new activity. In the last column indicate the total hours they are required to be in that activity during the course of their normal work day.

Activity	0-30 Minutes	31-60 Minutes	61-90 Minutes	> 90 Minutes	Total time per day
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Hours

Cognitive Job Demands - Select the option that describes how often they are performing each activity during their normal work day

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Attention to detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi tasking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading/Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL INFORMATION

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

DECLARATION

I declare the information I've entered is accurate.

Today's Date (MM/DD/YY): _____

Name of Contact Person _____

Job Title _____

Phone Number _____

Email Address _____

Confidential Fax Number _____

Authorized Signature _____

If submitting form by fax or email, the Authorized Signature field must be signed.

If submitting form online, online certification will be applied.