THE Great-West Life ASSURANCE COMPANY

Disability Application for Group Life Waiver of Premium Benefit Employer Statement

The Employer's and Employee's Statements should be completed and sent to Great-West Life at least 8 weeks before the waiting period ends. 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: _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

Complete every question in this section including a), b), and c).

Employee is:
a) ☐ Full-Time ☐ Part-Time
b) ☐ Permanent ☐ Temporary ☐ Seasonal ☐ Contract
c) ☐ Hourly ☐ Salaried ☐ Commissioned ☐ Salaried and Commissioned ☐ Hourly and Commissioned
☐ Other Description: _____

Regular number of scheduled hours: _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly

Do the scheduled hours vary (excluding overtime)? ☐ Yes ☐ 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 life insurance amount for the employee: _____

Does the employee have any optional life insurance? ☐ No ☐ Yes Amount of optional life insurance: _____

Are premiums still being paid? ☐ Yes ☐ No Date premiums stopped being paid: _____

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)

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.

THE Great-West Life ASSURANCE COMPANY

Job Questionnaire

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?

☐	Limited	Work activities involve handling loads up to 5 kg. For example: • Examining and analyzing financial information. • Administering and marking written tests.
☐	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.
☐	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.
☐	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

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	☐	☐	☐	☐
up to 50 lbs / 22.75 kg	☐	☐	☐	☐
up to 20 lbs / 9.1 kg	☐	☐	☐	☐
up to 10 lbs / 4.5 kg	☐	☐	☐	☐

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	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐

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	☐	☐	☐	☐	_____ Hours
Standing	☐	☐	☐	☐	_____ Hours
Walking	☐	☐	☐	☐	_____ Hours
Climbing	☐	☐	☐	☐	_____ Hours
Driving	☐	☐	☐	☐	_____ 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	☐	☐	☐	☐
Multi tasking	☐	☐	☐	☐
Analysis	☐	☐	☐	☐
Verbal communication	☐	☐	☐	☐
Reading/Writing	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Supervision of others	☐	☐	☐	☐

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.

Clear