IN THE MATTER OF AN ARBITRATION

under the *Labour Relations Act*

BETWEEN:

UNITED STEELWORKERS LOCAL 7949

(the "Union")

-AND-

FENNER DUNLOP INC.
(BRACEBRIDGE)

(the "Employer")

RE: Grievance GM-10-16

STD Plan

Before: SOLE ARBITRATOR: M.G. Mitchnick

APPEARANCES:

For the Union:

Dale Hogg, Staff Representative
Melissa Puccini-Lott, Local Union President
Rod Smith, Local Union Vice President
Gregg Mann, Witness

For the Employer:

John Hyde, Counsel
Corinna Barnes, HR Manager
Stefan Perkic, VP Manufacturing

Hearing held in Bracebridge, Ontario on August 14, 2017.

AWARD

In August of 2016 the company announced that it was turning over the administration of its Short-term Disability (STD) Plan to Great West Life. That was prompted in part by the elimination in the previous month of the Payroll Division at this Bracebridge facility itself. But more than that, the company was concerned about the time it was taking the plant's Human Resource Director, Corinna Barnes, to administer the Plan internally, as well as having concerns about the handling of confidential medical information, and the fact that this was not an area of expertise for the company's personnel. Great West Life for years has been the administrator of the company's Long-term Disability (LTD) Plan, and it only made sense from the company's perspective to enlist the expertise of that insurer to administer the Short-term Plan as well, so that employees when necessary could move seamlessly from one Plan into the other. To do that, however, the company has simply brought forward all of the Forms previously required by Great West Life to support an LTD claim. This, the Union says, has meant increased delays in payment along with significantly more information than has been required under the Short-term Disability Plan since that Plan's inception in the parties' first collective agreement in the mid-80's. The Union takes no issue with the decision of the company to enlist a third-party to administer the terms of the STD Plan; it grieves, however, that both the practice and the collective agreement have been clear and consistent for decades as to the extent of information required of an employee to support an STD claim, and that the Policy and procedure now adopted by the company is simply in violation of both.

The collective agreement does in fact stipulate the following:

ARTICLE XXIX – DISABILITY BENEFIT PLAN

29.01 …

(b) All absences over two (2) working days will be treated as an unpaid leave of absence. Short Term Disability begins on the third day of absence, if the employee seeks medical assessment on the third day and provides a medical note indicating doctor's assessment of disability. The note must detail the first date of assessment and the return date (if known). Employees are required to provide a doctor's note detailing the approved return to work date. Any absence longer than five working days will require the Medical Leave of Absence (MLOA) Functional Abilities Form (FAF) to be completed by a doctor and given to the Company by the fifth day of absence to continue receiving MLOA compensation. If a FAF can not be completed by the fifth day, due to doctor availability, the employee then must notify Human Resources of the scheduled date for FAF assessment.

(c) Scheduled overtime will not be treated as regular scheduled work for purposes of illness, therefore, will not be considered as the first or second day of absence. In the event the Company requests Doctors' notes, forms, etc. and there is a cost involved, the employee will pay the cost but will be reimbursed from the Company no later than ten (10) working days after submitting the bill to the Company.

. . .

Followed By

29.02 75% of the employee's weekly base rate (to a maximum of $675.00/week, $700.00/max in Year 3) for a (26) twenty-six week period.

Followed By

29.03 66.67% of the employee's weekly base rate (to a maximum of $5000/month) until recovery or death or age 65 years.

Mr. Greg Mann, giving brief evidence on behalf of the Union, was with the company for 36 years to the point of his recent retirement. He testified that over the course of his employment he has applied for STD on many occasions, and the requirement was always the same: if you were off three days and wanted pay for the third day, you went and got a doctor's note and it was in your next regular pay. As far as the content of the note, it indicated what day you were off, and when you were seen by the doctor, "that was basically it". If you were off longer, you needed to bring in a Functional Abilities Form (FAF) filled out by the doctor.

The company as well called one witness, Ms. Barnes herself. Ms. Barnes essentially confirmed what Mr. Mann said the practice on a "doctor's note" had been. It had to be clear that the note was actually from the doctor, that it indicated when the employee was seen, and the expected date of return, if known. As far as "indicating doctor's assessment of the disability", as referenced in Article 29.01, Ms. Barnes explained that that meant that the company was looking to the doctor to confirm that the employee was off work due to "medical reasons" – without having to indicate what those medical reasons were. For an absence lasting any longer than 5 days, an FAF filled out by the doctor was required as well, as soon as the employee was able to get back in to see their doctor to provide it. Once on STD, Ms. Barnes continued, she would just keep in contact with the employees every few weeks for updates and, depending how long they were off and how many follow-up appointments they had, she might request a further FAF to be provided by the doctor.

The current collective agreement runs from November 1, 2014 to October 31, 2017, and Ms. Barnes was part of the company team meeting with the Union to

negotiate that agreement in 2014. The evidence surrounding those negotiations is not in dispute. At some point in the negotiations the parties were discussing some issues around sick pay, and in the course of that Stefan Perkic, the Vice-President of Manufacturing, mentioned that it was the company's intention to move to a third-party administrator for the Short-term Plan (as already existed for the Long-term Plan). The Union's staff rep of the day responded that the Union has a Plan which can cover Short-term, and suggested that the company consider that. The staff representative went on to note that sometimes when a third-party is brought in the benefits get changed, and Ms. Barnes responded that any issues over that could be brought to her, as that was not the intent. The Union was asked, beyond that, whether they were looking for any change to the contract language, and the Union indicated that it was not.

The change to a third party administrator did not, as noted, take place until August of last year, and Ms. Barnes was asked in chief why it had taken so long for the company to follow through on this. Ms. Barnes responded that meetings with the insurer had to be co-ordinated, and that it does take some time to negotiate a program that ensures no big changes for the employees, or call for them to be doing anything that they were not required to do before. Asked on cross whether there *really* was nothing new, Ms. Barnes responded that she had thought about that after she said it, and although the employee was still required to provide the doctor's note and the FAF, there *were* in fact additional Forms that now were being required with the application, and that the Forms were different from what had been required of the employee for STD alone. What was required by way of the "doctor's note" previously has already been described, and the FAF that had been part of the support for an absence extending beyond 5 days is attached as Appendix A to this Award. Attached as Appendix B is the package that an employee, with the interjection of GWL as the administrator, is now required to submit for an STD claim. As one would expect, given the different standard of disability typically expected in a short- versus long-term disability claim (as well as the

stakes for the insurer), the difference in these two sets of requirements is far more than one of form, or superficial in nature. Apart from the company being required to complete a detailed Form as well before the claim will be assessed, the doctor is now required, amongst other things, to identify both a "Primary diagnosis" and "Secondary and/or Complications". Additionally, the following authorizations are required from the employee:

> **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.

And further:

> Great-West Life, any healthcare or rehabilitation provider, any 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 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;

All of this has been introduced in the face of a collective agreement which, unlike most, actually does specify the level of information that an employee will be required to supply to support an application for Short-term benefits, and the evidence of both parties lines up to confirm how limited that was.

The company's "defence" to this challenge to the change is that the Union cannot both approbate and reprobate. That is, what is being sought now with a Short-term Disability application is no different than what previously had been sought by the insurer for Long-term Disability, and there has never been any complaint by either the Union or its members in the case of the latter. What *is* different, however, is that the collective agreement is silent on what can be required of an employee for purposes of qualifying for *Long*-term benefits; in contrast to the case of Short-term benefits, where the Union has negotiated into its collective agreement very specific language as to what is required to support the claim. While, as Mr. Hyde fairly points out, clause (c) of Article 29.01 does make reference to any company requests for "forms, etc." in the plural, the evidence is clear as to what additional Forms, at a later point in time, the company was in the practice of requesting, and this blanket statement about covering the cost of such Forms cannot be read as over-riding the detailed and explicit language of 29.01(b). In contrast to the language here, *OPSEU and Ontario Public Service Staff Union* (1987), 28 L.A.C. (3rd) 10 (Saltman), was a case in which the arbitrator noted that "there was nothing in the collective agreement which required negotiation with the union regarding a change in the methodology for claiming insured benefits"; and that the relevant article of the collective agreement "is limited by its express terms to changes in benefit coverage". Any changes in procedural requirements, accordingly, were left to the unrestricted rights of management. *West Coast Energy*, 2004 CarswellNat 7565 (Hall), is the same, noting at paragraph 10: "Thus, the absence of collective agreement language here establishing a procedure for claiming short term disability benefits does not preclude the Employer from introducing a uniform policy, including a requirement that forms be completed to support an application for benefits".

In sum, I am of the view that Ms. Barnes instinctively had it exactly right in looking to set this up with the insurance company: in moving the responsibility for

administering short-term disability claims away from the company and putting it in the hands of third-party professionals, it was important that the transition [at least if done during the period of the current collective agreement] be effected without requiring the employees "to do anything that they were not required to do before". Unfortunately, I have to find that the company has demonstrably failed in the execution of that goal.

Notwithstanding the efforts of Mr. Hyde, therefore, I conclude that the grievance must be upheld, and as requested direct that the company "withdraw the Third Party Short Term Disability Administration Policy" implemented in August of last year, and that if it wishes to continue to engage the services of a third party to administer its Short-Term Plan, it ensure that the demands of the third party are consistent with the language and practice in effect under the parties' collective agreement.

Although I recognize that this current collective agreement is nearing its expiration in any event, I will remain seized of the matter in the usual way to deal with any disputes that may arise with respect to the implementation of my Award.

Dated at Toronto this 31st day of August, 2017.

Arbitrator

FENNER DUNLOP
ENGINEERED CONVEYOR SOLUTIONS

Appendix A

FUNCTIONAL ABILITIES FORM FOR TIMELY RETURN TO WORK

700 Eccelstone Drive
Bracebridge, Ontario, Canada P1L 1W1
Tel: (705) 645-4431, FAX: (705) 645-5430

ATTENTION PHYSICIAN: MODIFIED WORK AVAILABLE -

Employee's Last Name	First Name
Full Address (No., Street, Apt.)	
City/Town	Province
Postal Code	Area Code Telephone
Date of Birth: day month year	

Supervisor's Last Name	First Name

Employee's Position Title:	
Department:	
Location:	

The following information should be completed by the Health Professional: Please Complete *ALL* Sections

1) Date of examination on which the report is based. — Restrictions identified through job description review (attached) yes ☐ no ☐

2) Rehabilitation/Treatment Required? ☐ Yes ☐ No (see attached additional information needed) — Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No If no, please complete next section.

3) Please complete where capabilities are known or limitations recommended.
Note: As tolerated implies that restrictions are recommended but must be quantified in the workplace.

Capabilities

Walking:	short distance only ☐		as tolerated ☐					
Standing:	less than 15 min ☐		less than 30 min. ☐		as tolerated ☐		other ☐	
Sitting:	less than 30 min ☐		less than 1 hour ☐		as tolerated ☐		other ☐	
Lifting floor to waist:	less than 10 kg ☐		less than 25 kg ☐		as tolerated ☐		other ☐	
Lifting waist to Shoulder:	less than 10 kg ☐		less than 25 kg ☐		as tolerated ☐		other ☐	

Stair climbing: none ☐ 2-3 steps only ☐ short flight ☐ own pace ☐ as tolerated ☐

Ladder climbing: none ☐ 2-3 steps only ☐ short flight ☐ own pace ☐ as tolerated ☐

Limited ability to use hand to: hold objects ☐ grip ☐ type ☐ write ☐

Limitations

☐ Bending or twisting of
☐ Chemical exposure to
☐ Operating motorized equipment
☐ Above-shoulder activity
☐ Repetitive movement of
☐ Environmental exposure to
☐ Restrictions related to medications: (specify)
☐ Below-shoulder activity

Can employee drive a forklift? : YES ☐ NO ☐
Can employee run overhead crane? : YES ☐ NO ☐

General Comments / Specific Limitations

Prescriptions : yes ☐ no ☐
List below indicating possible impairment:

4) Recommendation for Work Hours ☐ Full-time hours ☐ Modified hours ☐ Graduated hours

5) If worker is restricted from working shift work, explain in more detail under "General Comments above.

Estimated duration of Limitations

Health Professional - please complete section below and send ONE copy by fax or mail to Fenner Dunlop

Health Professional's Name (Please print)	Health Profession	Date of Next Appointment day month year
Full Address	City/Town	Province Postal Code
Date (dd/mm/yyyy)	Area Code Telephone	Signature

FENNER DUNLOP
ENGINEERED CONVEYOR SOLUTIONS

700 Eccelstone Drive
Bracebridge, Ontario, Canada P1L 1W1
Tel: (705) 645-4431, FAX: (705) 645-5430

FUNCTIONAL ABILITIES FORM FOR TIMELY RETURN TO WORK (ongoing treatment plan)

ATTENTION PHYSICIAN: MODIFIED WORK AVAILABLE

TREATMENT PLAN

(1) Doctor & Specialist Appointment Plan (example: weekly, biweekly, monthly, etc)

(2) Medication and/or Surgical Intervention Plan (please ONLY circle below)

Medication Plan - YES NO
Surgical Intervention - YES NO

(3) Plan for Return to Work (RTW) (Approximate Date of RTW, full/restricted duties, etc.)

(4) Continuing Medical Follow-up Plan After RTW

Appendix B

THE Great-West Life ASSURANCE COMPANY

Application for Group Short Term Disability Benefits - Employer's Statement

Important:

The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed in their entirety and submitted 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 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	PO Box	City	Province	Postal code

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth
Address: Street & Number	PO Box		City	Province	Postal Code
Telephone Number	Cell 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 submit copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If no, is a return to work date known?	Has employment terminated?
☐ Yes _____ (MM/DD/YY) ☐ No	☐ Yes _____ (MM/DD/YY) ☐ No	☐ Yes _____ (MM/DD/YY) ☐ No

D. INSURANCE INFORMATION

Date employee became insured under the Short Term Disability Plan. (MM/DD/YY) _____	When did the employee apply for insurance? (MM/DD/YY) _____	Effective date of excess insurance, 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.

Employee's Gross Weekly Earnings: $ _____ per week	Average monthly commissions earned in the 24 months ending on the last day worked:	Employee benefit amount (according to your records):	TD-1 Federal personal tax credits:	For Quebec residents, tax deductions according to the latest TP-1015.3:

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☐ Yes ☐ No

If yes, percentage of employment income that is tax exempt: _____ %

DECLARATION

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

Name (please print): _____ Date: _____

Title: _____ Phone: _____

Authorized Signature: _____ Fax: _____

If submitting form by fax or mail, the **Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.

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 submit it.

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 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.

Name (please print): _____ Date: _____

Title: _____ Phone: _____

Supervisor or Authorized Signature: _____ Fax: _____

If submitting form by fax or mail, the **Supervisor or Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.

Short Term Disability Income Benefit

Employee's Guide

THE
Great-West Life
ASSURANCE COMPANY

THE Great-West Life ASSURANCE COMPANY

Short Term Disability Income Benefits

This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within ten days of the onset of your disability. 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.

Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

THE Great-West Life ASSURANCE COMPANY

Short Term Disability Income Benefits
Employee's Statement

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. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   City _____ Province _____ Postal Code _____

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

   Cell (_____) _____ ☐ Confidential

   If you wish us to leave a detailed message with personal information about your claim at a number, check the box marked "confidential" beside that number. Otherwise, we will only leave a general message with callback information at that number.

   Email address: _____

   If you would like Great-West Life to communicate with you by email about your disability claim, please fill in your email address. Emails Great-West Life sends to this address will be sent securely using Proofpoint Secure Email.

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? _____
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
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. Please provide the name(s) and telephone number(s) of your attending physician(s).

   _____

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	☐	☐	☐	☐	$ _____
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ _____
Employment Insurance Benefits	☐	☐	☐	☐	$ _____
Automobile Insurance Benefits	☐	☐	☐	☐	$ _____
Any other Disability Benefits	☐	☐	☐	☐	$ _____
Employer Sponsored Retirement / Pension Plan Income	☐	☐	☐	☐	$ _____
Self Employment Income or any other Employment Income			☐	☐	$ _____
Any other income	☐	☐	☐	☐	$ _____

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 THE INITIAL BENEFIT STATEMENTS.

DIRECT DEPOSIT AUTHORIZATION

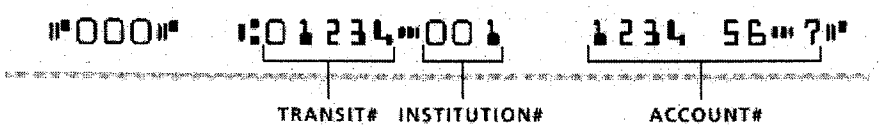
Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account.**

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.



TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
___ ___ ___ ___ ___	___ ___ ___	_____

NAME OF BANK, TRUST CO, CREDIT UNION, ETC.

DATE

SIGNATURE OF EMPLOYEE

THE Great-West Life ASSURANCE COMPANY

Application for Disability Income Benefits
Employee's Authorization Request

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, 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.

Group Plan Number	GWL Employee Identification Number
Print Employee Name	Employee Signature
Date	Telephone Number

CLHIA ACCAP

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

THE Great-West Life ASSURANCE COMPANY

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

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

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	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:

_____

_____

CLHIA ACCAP

THE Great-West Life ASSURANCE COMPANY

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)	

THE
Great-West Life
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www.greatwestlife.com

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