

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 five days of the onset of your disability. All completed forms, and any other correspondence you may wish to provide about your claim, should be submitted to CHIPS' Plan Administrator (R. Spencer Mohart Insurance Consultants Ltd.) no later than 30 days after the commencement of your claim. **Claims submitted later than 30 days after the commencement of claim will be declined.**

1. Notice of Claim

The Notice of Claim 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 Policy 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 plan administrator, your employer, other insurers and hospitals where you received treatment.

3. Attending Physician's Report

Ask your doctor to complete this form in full. It requests general information about your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM

Administrator's Statement

Before we can assess your claim, your Plan Administrator contacts your employer to confirm the date your insurance coverage began, your job duties and earnings. Please do not complete any portion of this statement. Your Plan Administrator will contact your employer, on your behalf, for this information.

Claim Assessment

Submit your completed forms to your Plan Administrator. We will assess your claim as soon as we receive these completed forms from your Plan Administrator.

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.

Return Completed Forms To:

R. Spencer Mohart Insurance Consultants Ltd.
P.O. Box 3096
Langley, BC V3A 4R3
Telephone: 604 533-5144 1-800-883-7526

NOTICE OF CLAIM

Identification

1. Mr. Mrs. Ms.

Your Name: First _____ Initial _____ Last _____

Address: Street & Number _____

P.O. Box _____

City _____ Province _____ Postal Code _____

Telephone: Home (_____) _____

2. Your GWL/CHIPS Employee Identification Number _____

Your Identification number must be completed. If unknown, please check with your Plan Administrator.

3. Social Insurance Number _____

I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number only where required in the administration of my benefits.

Employee's Signature _____

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 Policy Number _____

Policy number must be completed. If unknown, please check with Plan Administrator.

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		Amount
	Yes	No	Yes	No	
Canada Pension Plan/Quebec Pension Plan Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Workers' Compensation Board Benefits (or similar plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employment Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Automobile Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Sponsored Retirement / Pension Plan Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Self Employment Income or any other Employment Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

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 or Life Insurance Coverage with Great-West Life, Canada Life or London Life? Yes No If so, please provide your policy number: _____

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

Date: _____ Signature: _____

DIRECT DEPOSIT AUTHORIZATION

You can have your benefit payment cheques automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life.

If you would like to take advantage of Electronic Funds Transfer, please complete the attached Direct Deposit Authorization form (page 7).

Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in 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 information in your files 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 information to investigate and assess your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments;
- Great-West Life to exchange my information with my plan administrator, R. Spencer Mohart Insurance Consultants Ltd. or my employer when relevant for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West Life to release information about my claim to an auditor authorized by my plan administrator, R. Spencer Mohart Insurance Consultants Ltd. or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims.
- Great-West Life to exchange my information with my plan administrator, R. Spencer Mohart Insurance Consultants Ltd. when relevant for the purpose of assisting with the assessment of my claim.
- Great-West Life to exchange my information with my plan administrator, R. Spencer Mohart Insurance Consultants Ltd. when relevant for the purpose of assisting in any arbitration or appeal processes.

Except for audit purposes, this authorization 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 Employee's Statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

Print Name

Signature

Date

Telephone Number

ATTENDING PHYSICIAN'S INITIAL STATEMENT DISABILITY INCOME BENEFITS

All forms must be received in the Administrator's office within 30 days from the date of commencement of illness/disability

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of Patient: _____ Employee Identification # _____
 Name of Employer: _____ Plan Number _____

I hereby authorize the release of any information requested on this form to The Great-West Life Assurance Company or any of its agents.

Date: _____ Signature of Patient: _____

1. History

Date symptoms first appeared or accident happened. Year _____ Month _____ Day _____

Has patient ever had the same or similar condition? Yes No

If yes, please specify diagnosis and dates of treatment _____

2. Diagnosis (including any complications)

Primary _____

Secondary _____

Subjective Symptoms: _____

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

3. Current Height _____ Current Weight _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

Year _____ Month _____ Day _____

5. Treatment

What is the current treatment regimen? (drug dosage, physio, other and progress)

Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				

6. If condition is due to pregnancy, what is (or was) the expected date of confinement?

Year _____ Month _____ Day _____

7. Is the condition due to injury or sickness arising out of the patient's employment? Yes No

If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? Yes No

8. Please indicate your patient's current physical abilities:

- Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.
- Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.
- Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.
- Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

List physical restrictions and tolerances: _____

In your opinion, what is the earliest date your patient will be able to return to work?

Year _____ Month _____ Day _____

If the previous job could be modified, when could rehabilitation employment commence?

Year _____ Month _____ Day _____

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

10. Hospitalization if applicable for this illness or injury

Date of in-patient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of out-patient treatment: Year _____ Month _____ Day _____

Name of hospital: _____

11. Surgery

Surgical procedure performed: _____

Date of surgery: Year _____ Month _____ Day _____

Name of surgeon: _____

12. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Address (number, street, city, province & postal code):

Physician's signature _____ Date _____

Direct Deposit Authorization
 Group Disability Insurance

Policy #	Social Insurance #	Employee #	Employee's Name
Effective _____ (mm,dd,year)	Please deposit my disability payments to the following account: <input type="checkbox"/> Savings account (consult your bank for the proper bank identification number) <input type="checkbox"/> Chequing account (attach sample cheque marked "void")		

PLEASE PRINT

Name of bank, trust co., credit union, etc.	Bank #	Transit #	Account #
Branch address	Name of account holder		
City/Town, Province	Postal code	_____	
	Date	Signature of employee	
NOTE: for Canadian institutions only			