Healthcare Benefit Trust (HBT) Policy 51337 ☐
Joint Community Benefits Trust (JCBT) Policy 59234 ☐
Joint Facilities Benefits Trust (JFBT) Policy 59233 ☐
Joint Health Science Benefits Trust (JHSBT) Policy 59232 ☐
Community Social Services Employers' Association (CSSEA) HBT Policy 51367 ☐
Healthcare Benefit Trust (HBT) Policy 50168 ☐

Claim for Long Term Disability Benefits

CLAIMANT'S STATEMENT

This statement is to be completed if you are applying for Long Term Disability (LTD) benefits through one of the Trusts/policies indicated above. The form should be completed and submitted to your employer along with any further information requested below. Your employer will then submit your claim to Canada Life.

It is also necessary that you ask your doctor(s) to complete an Attending Physician's Statement as part of your claim. Your doctor may return the completed form to you or send it directly to Canada Life. Please note that you are responsible for providing proof that you are entitled to benefits and for paying any fees which your doctor may charge to provide this material. Considerable information is required from you and your doctor in order that your claim may be correctly assessed, and we ask for your patience and cooperation in complying with all requests from Canada Life for additional information.

If you have any questions about the provisions of your LTD Plan, please refer to your Collective Agreement or your benefit booklet, or contact your employer or your union. If you have any questions about the status of your claim, please contact Canada Life at 604-646-1200 (Vancouver) or 604-455-2700 (Langley) or toll-free at 1-888-292-4111.

Note: Your LTD benefit is provided by one of the benefits trusts indicated above (in this Claimant's Statement, it is referred to as the "Trust"). The Trust is exclusively dedicated to providing certain employee benefits and services related to those benefits. The Trust is not an insurance company and the benefits it provides are not insured by an insurance company. The Trust is not subject to regulation under the British Columbia *Financial Institutions Act*.

Employee Identification *(please print)*

1. **Name:** _____
Last First Initial

Address: _____
Number & Street City Province Postal Code

Telephone #s: Primary _____ ☐ Confidential
Secondary (Cell) _____ ☐ Confidential

Check the "confidential" box if you authorize Canada Life to leave a message containing personal information about your claim at that number.

Email Address: _____

Include your email address in order that Canada Life can communicate with you by secure email about your LTD claim.

2. **Gender:** ☐ Male ☐ Female ☐ Non-Binary ☐ Undisclosed

3. **Date of Birth** ____ ____ ____
Day Month Year

4. **HBT Benefits ID No. (BID)** _____

5. **Social Insurance Number:** *(for tax purposes only)* ___ - ___ - ___

6. **Job Title:** _____

7. **Union** (*if applicable):* _____

8. **Collective Agreement:** _____

Employer Information

Employer: _____ Department/Program: _____

Name of employer contact: _____ Work relationship: _____
Manager, Disability Management Advisor, Supervisor, etc.

Telephone #: _____ Email address: _____

Claim Information

1. What was the date of the first shift when your condition prevented you from performing your regular hours of work and duties? ____ ____ ____
Day Month Year

2. When did your health first become affected? ____ ____ ____
Day Month Year

3. Were you hospitalized for this condition? ☐ Yes ☐ No If yes, provide the date(s) and hospital name(s):

_____

4. Describe your present **condition**, its **cause** and **history** to date. If injured, indicate the nature of the accident. (*If you require more space, use the Additional Information section.)*

5. When do you expect to be able to return to: (a) Your own job? Day Month Year (b) Another job? Day Month Year

6. Have you attempted to return to work? ☐ Yes ☐ No

   If yes, on what basis: ☐ Full-time ☐ Part-time ☐ Usual job ☐ New job/duties

   Give dates you returned to work: Day Month Year to Day Month Year

7. Have you received any earnings from another employer since you last worked? ☐ Yes ☐ No

   If yes, name the employer:

8. Name **all** the physicians who have attended you for this condition:

Physician	Speciality	Address	Date of First Visit	Date of Latest Visit

Offsetting Income

Provide the details of **any** benefits which you are, or will be, claiming from other sources with respect to **this** condition.

1. Canada Pension Plan Disability Benefits *(Please enclose copies of all correspondence and documents from CPP such as Notice of Entitlement or letter denying your claim.)*

Applied? ☐ Yes ☐ No Date applied: Day Month Year

Monthly Benefit: $ Paid from: Day Month Year to Day Month Year

Denied? ☐ Yes ☐ No Date denied: Day Month Year

Appealed denial? ☐ Yes ☐ No Date appealed: Day Month Year

2. WorkSafeBC (*Please enclose copies of all correspondence and documents from WorkSafeBC.)*

Claim #: Adjudicator's Name:

WorkSafeBC Office Address:

Benefit: $ /week Paid from: Day Month Year to Day Month Year

Have you ever received a Permanent Partial Disability (PPD) award? ☐ Yes ☐ No

Date received: Day Month Year Monthly PPD benefit: $ OR Lump Sum Settlement: $

If your claim has been denied or terminated, have you appealed the decision? ☐ Yes ☐ No Date appealed: Day Month Year

3. ICBC *(Please enclose copies of all correspondence and documents from ICBC.)*

Claim #:

Adjuster: Lawyer:

Address: Address:

Telephone: Telephone:

4. Other Disability Benefits *(If you require more space, use the Additional Information section.)*

Benefits: $ _____ ☐ Weekly ☐ Monthly

Name of Insurer: _____

Address: _____

Policy Number: _____ Type of Benefit: _____

Additional Information *(Use this page if additional space is required to answer questions.)*

Protecting Your Personal Information

This section explains how your personal information will be used to administer your Long Term Disability (LTD) claim. The Trust and Canada Life respect your privacy and keep your personal information (including medical information) in confidential files. Only those who need your personal information to perform their duties, those to whom you grant access and those with a legal right to access your personal information will have such access. Any reference to "Trust" in this authorization section means one of the Trusts indicated on the first page, the Trustees of that Trust, their agents (including the Healthcare Benefit Trust where the Trust is not the Healthcare Benefit Trust) and Canada Life.

By signing this Form, I authorize the Trust to:

- collect, use and disclose my personal information (non-medical and medical), if reasonably necessary to (1) investigate, assess and/or administer my claim (including, but not limited to rehabilitation and return to work planning) or (2) administer the LTD Plan (including, but not limited to, auditing the LTD Plan). To clarify, I also authorize an exchange of my personal information among the Trust and its agents for those purposes;
- exchange my personal information (non-medical and medical) with any physician; health practitioner; healthcare or rehabilitation provider; independent medical examiner; any person who has or who may in the future, examine, treat or diagnose me; any hospital or clinic where I have or may become a patient; or any insurance company or any other organization with records or knowledge of me or my health, if the exchange is reasonably necessary to investigate, assess and/or administer my claim;
- exchange with my employer(s), my non-medical personal information as is reasonably necessary to investigate, assess and/or administer my claim or to assist my employer manage my absence, including rehabilitation and return to work planning. This may include information about my restrictions, limitations, abilities, and prognosis for rehabilitation and return to work.
- Claimants who are members of a union: Exchange with my union and/or bargaining association, my non-medical personal information as is reasonably necessary to assist my union and/or bargaining association to (1) represent me in respect of my claim, (2) bargain collectively in respect of the LTD Plan or (3) otherwise discharge its duties as my union/bargaining agent in respect of the benefits that are provided by the Trust including, without limitation, the Early Retirement Incentive Benefit program if it is part of the LTD Plan in which I participate.

By signing this Form, I declare that:

- my authorization will be effective until all aspects of my claim are complete including (but not limited to), the investigation, assessment and administration of my claim and any appeals, even if aspects occur after my benefits cease;
- I understand that the Trust must collect, use and disclose my Social Insurance Number to administer my claim;
- the statements I make on this Form and in the course of any personal or telephone interviews that relate to my claim, will be true and complete, and I understand that any benefits I receive are dependent on the truth of those statements.

Name *(please print):* _____ **Signature:** _____

Date: _____ **Telephone Number:** _____

Benefits Identification Number: _____

Name: _____ **HBT Benefits ID No. (BID):** _____

Summary of Education, Training and Experience

EDUCATION	Location	Level Obtained	Year	Areas of Study & Years Completed
Elementary or High School				
College or University				
Other *(Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.). Attach additional pages if necessary.*				

WORK EXPERIENCE:
(Begin with most recent but include every job you have had. Attach extra sheets if necessary, or your resumé.)

Duration of Employment		Employer	Job Title and Duties
From	To		

ACQUIRED SKILLS:
(These may include word processing, operation of equipment, supervisory skills, special licenses, etc. Where appropriate give level, speed or proficiency.)

_____

_____

_____

Volunteer work, hobbies and interests:

_____

_____

_____

LICENSES:

Do you have a valid driver's license? ☐ Yes ☐ No If yes, list any restrictions: _____

Do you hold other professional licenses? ☐ Yes ☐ No If yes, provide details including type of license, class, active/inactive status, renewal date, restrictions, etc. as applicable: _____

_____

Date form completed: _____ _____ _____ **Signature of claimant:** _____
Day Month Year

Clear Data