

Fax or mail original to:

GREAT WEST LIFE DISABILITY SERVICES
P.O. Box 43030 or 43180
Mavis Road PO
Mississauga, On L5B 4A7
Tel.: 1-866-625-1483
Fax: 1-866-624-3612

In order to properly process your disability claim, The Claims Administrators must receive all portions of the claim paperwork completed in full and signed. Failure to do so may result in processing delays of your claim and affect payment. To expedite the process, please fax the GDIP claim request form to 1-866-624-3612 or send the original by mail with all necessary supporting documentation to the above address.

TO BE COMPLETED BY EMPLOYEE

Last Name: _____ First Name: _____
 Employee Number: _____ Date of Birth: (DD/MM/YY) _____ Job Position: _____
 Telephone Number : _____ e-mail address: _____
 Mailing Address: _____ City: _____ Province: _____ Postal Code: _____
 Manager's Name: (If known) _____ Manager's Telephone Number: _____

Offset Provision: If income from the sources listed below is payable to you during the same period as any monthly income benefits payable under this claim, it will be deducted from those benefits.

Reportable Income

	I have applied		I am receiving		Amount	
	Yes	No	Yes	No		
Canada Pension Plan/Quebec Pension Plan Benefits or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	Per month
Worker's Compensation Board Benefits (or similar plan) except for: a) permanent partial disability awards that were payable for each of the 12 months before a disability period; and b) benefits related to employment with another employer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	Per week
Periodic payments from any retirement plan except for that portion you were already receiving before the commencement of the disability period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	Per week/month
Indemnity benefits for loss of time to which you are entitled under any No-Fault Insurance Law or similar law requiring or providing such coverage for or on account of an accidental bodily injury or for which a private automobile insurance company is liable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	Per week/month
Any remuneration you may receive from the Employer or from any other employer, except for that portion you were already receiving before the commencement of the disability period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	Per week/month

- 1) I agree to notify Great West Life of any Reportable Income that I receive or become entitled to.
- 2) I agree to provide this notice within 30 days after Reportable Income is first received or awarded.
- 3) I recognize and accept my obligation to repay any benefits that are overpaid according to the terms of Group Plan 51208 as a result of my entitlement to Reportable Income, or otherwise. If my benefits are overpaid, I am responsible for repayment within 6 months, or within a longer period if agreed to by Great West Life. If I fail to fulfill this responsibility, I agree that further benefits may be withheld until the overpayment is recovered.

Signature: _____

Date: _____

Last Date Worked:
(DD/MM/YY)

NOTE: If it was an Air Canada work-related illness/injury, be sure that a Workers' Compensation Board accident report has been completed.

Are you absent due to: work-related illness / injury Yes No

Brief Description of illness / injury:

Date of Accident:
(DD/MM/YY)

Location of Accident:

Are you absent due to: non work-related illness / injury Yes No

Brief Description of illness / injury:

Date of Accident:
(DD/MM/YY)

Location of Accident:

Treating Physician Information:

Name of Physician:

Mailing Address:

Postal Code:

Telephone Number:

Fax Number:

List any physicians/care providers consulted for present condition (including specialists, physiotherapists, counsellors, EAP, etc.):

Name

Specialty

Address

Telephone

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. 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. We use information to investigate and access your claim and to administer the group benefit plan.

Authorizations and Declarations

I authorize:

- **Great-West Life** and its agents to exchange my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan, or performing independent assessments.
- My Treating Physicians and/or any health care providers that I have consulted to disclose to **Great West Life** and its agents all medical and psychiatric information relevant to the assessment and administration of this claim. I further authorize **Great West Life** and its agents to communicate with my Treating Physicians and/or any health care providers that I have consulted and to disclose to them any and all medical and psychiatric information relevant to the assessment and administration of this claim.
- For the purpose of discussing rehabilitation and return-to-work planning, **Great West Life** and its agents to exchange information regarding my restrictions, limitations, capabilities and duration of the claim with my employer when necessary.
- For the purpose of discussing rehabilitation and return-to-work planning, **Great West Life** and its agents to exchange information regarding my restrictions, limitations, capabilities, medical information, and duration of the claim with Air Canada Occupational Health Services when necessary.
- **Great West Life** and its agents to release information about this claim to an auditor authorized by my employer or their agent at any time for the purpose of auditing the assessment of the claims.

I confirm that a photocopy or electronic copy of this authorisation shall be as valid as the original.

I declare that all information which I have or will provide to **Great West Life** and its agents with respect to this claim is true and accurate.

Employee Name (Please print)

Employee Signature

Date

In the event that a dispute arises with respect to this claim or to my continuing entitlement to income benefits, I authorize and direct that the Claims Administrators provide to the IAMAW Local Lodge (please insert Local Lodge number) _____ and its representatives any information and documents from this claim file that they request for the purpose of representing me in such dispute. I understand that this may include any and all medical and psychiatric information and documents included therein.

Employee Signature: _____

Fax or mail original to:

GREAT WEST LIFE DISABILITY SERVICES P.O. Box 43030 or 43180 Mavis Road PO Mississauga, On L5B 4A7 Tel.: 1-866-625-1483 Fax: 1-866-624-3612

In order for a claim to be qualified for Group Disability Income Plan (GDIP) benefits under the company's plan, the medical documentation must contain clinical findings and detailed medical information which establishes not simply the presence of a medical condition but rather that there is evidence of an impairment severe enough to prevent your patient/client from participating in work.

- It is the employee's responsibility to provide medical information to support an application for income protection and to pay any costs incurred in obtaining this information.
- This is not a request for examination, but for information taken from your chart.

EMPLOYEE NAME:		ID:	DOB (DD/MM/YY)	
TO BE COMPLETED BY THE TREATING PHYSICIAN			PLEASE PRINT CLEARLY	
Date patient first consulted for this disability (DD/MM/YY):				
Date of most recent visit (DD/MM/YY):				
Frequency of visits:	Once per week <input type="checkbox"/>	Every two weeks <input type="checkbox"/>	Other:	
Date of hospitalization or surgery (past and/or present, if applicable):	Hospital:			
	Date of admittance:			
	Date of discharge:			
	Date of surgery:			
	Procedure:			
1 ° Diagnosis:			2 ° Diagnosis:	
Date symptoms first appeared for this disability (DD/MM/YY):				
Severity of condition :	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Are there any co-morbid conditions that may impede the recovery from this illness (e.g. diabetes)?				
Prognosis:				
DSM IV (if applicable) :	Axis I (clinical syndrome):			
	Axis II (personality trait disorder):			
	Axis III (physical condition):			
	Axis IV (contributing psychosocial factors) :			
	Axis V : (GAF)			
Precipitating effects:	Are work related issues contributing to your patient's condition? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please Specify)			
Subjective symptoms:				
Objective signs:				
Is there a previous history of this illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO If <<YES>> state when and describe:			
Current medical status:	1 st VISIT <input type="checkbox"/>	Improved <input type="checkbox"/>	Unchanged <input type="checkbox"/> (please advise of change in treatment)	Worse <input type="checkbox"/> (please describe the complications in

TESTS - PLEASE PROVIDE COPIES OF ALL RELEVANT REPORTS WHICH MAY ASSIST IN ASSESSMENT OF CLAIM-

<input type="checkbox"/> Laboratory	<input type="checkbox"/> X-Ray	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> CT Scan	<input type="checkbox"/> ECG	<input type="checkbox"/> Stress Test	<input type="checkbox"/> EMG
<input type="checkbox"/> Angiogram	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> Other		

REFERRALS - PLEASE PROVIDE COPIES OF ANY CONSULTATION/PROGRESS REPORTS -

Referral to: _____ Appt. Date: _____
 (name & specialty) DD MM YY

Referral to: _____ Appt. Date: _____
 (name & specialty) DD MM YY

AWAITING REFERRAL YES NO

TREATMENT / RECOMMENDATIONS

<input type="checkbox"/> Physiotherapy / Occupational Therapy Start date: Frequency:	<input type="checkbox"/> Chiropractor Start date: Frequency:	<input type="checkbox"/> Splint Removal date :
<input type="checkbox"/> Cast Removal date: Date:	<input type="checkbox"/> Angioplasty Date :	<input type="checkbox"/> Psychotherapy Start Date : Frequency:
<input type="checkbox"/> Radio Therapy Frequency: Duration:	<input type="checkbox"/> Chemotherapy Type: Frequency: Duration:	<input type="checkbox"/> Other

PLEASE LIST ALL MEDICATIONS RELATED TO CURRENT ILLNESS:

Generic or Trade name	Dose (i.e. 75 mg, bid)	Start/Change Date	Response (good, poor, none)
1.			
2.			
3.			
4.			

FUNCTIONAL ABILITIES:

Please check clearly what level of activity your patient is able to perform, as applicable to diagnosis/condition: **Please Note: the Company has a Modified Return to Work Program and will seek to accommodate employees who are unable to perform their normal job duties.**

ABILITY

STAND 15 MIN 30 MIN 60 MIN NO LIMITATION OTHER

WALK SHORT DISTANCES ONLY NO LIMITATION TOTALLY UNABLE TO WALK

SIT 15 MIN 30 MIN 60 MIN NO LIMITATION OTHER

LIFT/CARRY: FLOOR - WAIST

LESS THAN 5 KG (11 LBS) LESS THAN 10 KG (22 LBS) LESS THAN 20 KG (44 LBS) OTHER

LIFT/CARRY: WAIST - SHOULDER

LESS THAN 5 KG (11 LBS) LESS THAN 10 KG (22 LBS) LESS THAN 20 KG (44 LBS) OTHER

LIFT/CARRY: ABOVE SHOULDER

LESS THAN 5 KG (11 LBS) AS TOLERATED LESS THAN 10 KG (22 LBS) LESS THAN 20 KG (44 LBS) OTHER

FUNCTIONAL ABILITIES - CONTINUED

CLIMB: STAIRS	<input type="checkbox"/> 2 – 3 STEPS	<input type="checkbox"/> SHORT FLIGHT	<input type="checkbox"/> OWN PACE	<input type="checkbox"/> AS TOLERATED
CLIMB: LADDER	<input type="checkbox"/> 2 – 3 STEPS	<input type="checkbox"/> OWN PACE	<input type="checkbox"/> AS TOLERATED	
LIMITED ABILITY TO USE HAND TO:		<input type="checkbox"/> HOLD OBJECTS	<input type="checkbox"/> GRIP	<input type="checkbox"/> TYPE AT KEYBOARD
		<input type="checkbox"/> WRITE	<input type="checkbox"/> FINE MANIPULATION	

PHYSICAL ABILITY	PARTIALLY REDUCED		TOTALLY REDUCED		
Operate mechanical equipment	<input type="checkbox"/>		<input type="checkbox"/>		Consecutive hrs
Operate motor vehicle	<input type="checkbox"/>		<input type="checkbox"/>		Consecutive hrs
Bend/ twist: neck	<input type="checkbox"/>		<input type="checkbox"/>		
Bend/ twist: back	<input type="checkbox"/>		<input type="checkbox"/>		
Push/ pull	<input type="checkbox"/>		<input type="checkbox"/>		kg/ lb
Reach: below shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R	Consecutive hrs
Reach: above shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R	Consecutive hrs
Sight	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R	
Hearing	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R	
Speech	<input type="checkbox"/>		<input type="checkbox"/>		
Balance	<input type="checkbox"/>		<input type="checkbox"/>		
Concentration	<input type="checkbox"/>		<input type="checkbox"/>		

CURRENT TREATMENT PLAN - Please describe

RETURN TO WORK

Is complete recovery expected?

Yes No Unknown

Accommodations: Reduced hours - please provide details

Modified duties as above

P. S. Kindly include a copy of your clinical notes, consult reports and any consultations/investigations pertinent and relevant from the first treatment date for the condition claimed to the date the form is completed.

CLINICAL NOTES FROM RECENT VISITS INCLUDED ___ YES ___ NO

ADDITIONAL COMMENTS:

Date of next consultation: _____

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN'S NAME – Please Print _____ PHONE _____ License Number _____