YOUR DISABILITY CLAIM

This claim form is used when claiming for benefit provided by your individual disability policy or for Waiver of Premium Benefit on your life insurance policy. At Great-West Life, your claim is important. If you have a claim, the following information will assist us in providing prompt service.

THE CLAIM FORM

The first and perhaps the most important step to adjudicating your claim is a fully completed claim form. You must complete the Claimant's Initial Statement portion of the claim form. Your physician whom you first consulted for your condition must complete the Physician's Initial Statement portion of the claim form.

Both forms must be completed and sent to Great-West Life's Head Office. Although the forms may be submitted separately, we will require both forms in order to adjudicate your claim. You must notify Great-West Life about your condition within 30 days of the onset of disability and forward satisfactory proof within 90 days. It is your responsibility to have the medical forms required to adjudicate your claim completed without expense to Great-West Life.

OUR FIRST CONTACT

Approximately two days after your Claimant's Initial Statement is received at Great-West Life's Head Office, your claim examiner will send you a letter acknowledging the receipt of your form. This letter will also provide you with the examiner's telephone number if you have any questions regarding your claim.

Your examiner will then review the claim once we receive both your Claimant's Initial Statement and the Physician's Initial Statement. Our claim forms are very complete and in most cases, no additional information will be required. If, however, additional information is required your examiner will contact you directly.

INITIAL DECISION

An initial decision will be made within 30 days of the claim being received at Great-West Life's Head Office. One of four decisions are possible. A brief description of each follows.

1. Approve the claim based on the evidence submitted.

If the information on the claim form is sufficient and all the conditions of the policy are met, the first monthly benefit will be paid 30 days after the waiting period has been satisfied.

Example: If your total disability began June 27 and your policy provides benefits after a 31 day waiting period, the first monthly benefit would be issued on August 26, for the period covering July 27 to August 26. Subsequent cheques will be mailed every 30 days as long as you still qualify for benefits under the terms of the policy.

2. Approve the claim with further benefits pending additional information.

The examiner may be able to pay one month of benefits, with further benefits pending the receipt of additional medical information. This method is used most often when the disability extends beyond the normal recovery period.

3. Request additional information before considering acceptance of the claim.

Some policies provide for coordination of benefits with Worker's Compensation or No-Fault Auto Benefits. In these cases, the examiner will need to know the amount of benefits you are eligible to receive from these two sources.

Other times, the portion of the claim form completed by the physician does not provide sufficient medical information to support a claim for disability. In those situations, the examiner may have to write directly to the physician.

4. Claim not accepted.

This occurs when the examiner determines that a term or condition of the policy has not been met. A letter of explanation will be provided by the examiner.

REQUEST FOR ADDITIONAL MEDICAL INFORMATION

When necessary, the examiner will write directly to the physician to obtain required information. If the examiner does not get a response within a month of the request, a follow-up letter is sent to the physician. At the same time, you and your insurance representative will automatically be notified by mail.

Depending on the nature of your medical condition, medical follow-ups will be requested on a periodic basis. The frequency will depend on your condition.

The following are examples of what we may require.

- a continuance claim form completed by you and your physician
- a narrative report from your attending physician
- consultation reports from any specialists you have consulted
- hospital admission history and care summary reports
- independent medical examination by a specialist. This examination will be paid for by Great-West Life

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 it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

HOW TO GET IN TOUCH

If you have questions about your claim, please get in touch through any of the following.

- Contact your claim examiner by telephone.
- Contact your claim examiner by mail or fax:

c/o The Great-West Life Assurance Company
Living Benefits Claims Department
P.O. Box 6000
Winnipeg, Manitoba, R3C 3A5
Phone: (204) 946-7511
Fax: (204) 946-8874

PROTECTING YOUR PERSONAL INFORMATION

At **The Great-West Life Assurance Company (Great-West Life),** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. 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. We collect, use and disclose the personal information to process this application and, if this application is approved, provide and service the financial product(s) applied for, advise you of products and services to help you plan for your financial security, investigate and process claims, and create and maintain records concerning our relationship.

THE Great-West Life ASSURANCE COMPANY

P.O. BOX 6000
WINNIPEG, CANADA R3C 3A5

CLAIMANT'S INITIAL STATEMENT

LIVING BENEFITS CLAIMS

NAME	DATE OF BIRTH	SOCIAL INSURANCE NUMBER
HOME ADDRESS POSTAL CODE _____		POLICY NUMBER(S)
TELEPHONE NUMBER ( ) _____		

NOTICE TO CLAIMANT:

PROVIDING COMPLETE DETAILS WILL HELP ELIMINATE DELAYS IN THE ADJUDICATION OF YOUR CLAIM. IN FURNISHING THIS OR OTHER CLAIM FORMS, THE COMPANY DOES NOT ADMIT ANY LIABILITY OR WAIVE ANY OF ITS RIGHTS.

BENEFITS BEING CLAIMED:

☐ TOTAL DISABILITY FROM ____/____/____ (D M Y) TO ____/____/____ (D M Y)

☐ PARTIAL/PROPORTIONATE DISABILITY FROM ____/____/____ (D M Y) TO ____/____/____ (D M Y)

INJURY

DATE OF ACCIDENT ____/____/____ (D M Y) TIME: ☐ AM ☐ PM

WAS ACCIDENT WORK RELATED? ☐ NO ☐ YES

HOW AND WHERE DID THE ACCIDENT OCCUR?

_____

_____

_____

DESCRIBE INJURIES SUSTAINED.

_____

_____

_____

HAVE YOU HAD THE SAME OR SIMILAR INJURY IN THE PAST? ☐ NO ☐ YES, PLEASE PROVIDE DETAILS.

_____

_____

_____

SICKNESS

DATE SYMPTOMS FIRST APPEARED ____/____/____ (D M Y)

DESCRIBE NATURE AND DETAILS OF SICKNESS.

_____

_____

_____

_____

HAVE YOU HAD THE SAME OR SIMILAR SICKNESS IN THE PAST? ☐ NO ☐ YES, PLEASE PROVIDE DETAILS.

_____

_____

_____

_____

_____

_____

_____

FOR DISABILITIES INVOLVING SHOULDER, ARM OR HAND, ARE YOU ☐ RIGHT HANDED OR ☐ LEFT HANDED

TREATMENT

ATTENDING PHYSICIANS' NAMES AND ADDRESS — DATE FIRST CONSULTED (D M Y)

_____ ____/____/____

_____ ____/____/____

_____ ____/____/____

IF YOU DID NOT CONSULT A PHYSICIAN ON THE DATE THE ACCIDENT OCCURRED OR SYMPTOMS FIRST APPEARED, PLEASE PROVIDE AN EXPLANATION.

_____

_____

ARE YOU STILL BEING TREATED? ☐ NO ☐ YES, PLEASE PROVIDE NATURE & FREQUENCY.

_____

WERE YOU HOSPITALIZED? ☐ NO ☐ YES FROM ____/____/____ (D M Y) TO ____/____/____ (D M Y)

NAME OF HOSPITAL(S) _____

EMPLOYMENT: ARE YOU SELF-EMPLOYED: ☐ NO ☐ YES

NAME OF EMPLOYER | TELEPHONE NUMBER ( )

ADDRESS

STREET & NUMBER | CITY | PROVINCE | POSTAL CODE

OCCUPATIONAL INFORMATION

JOB TITLE _____

NATURE OF BUSINESS _____

HOW MANY HOURS WORKED PER WEEK PRIOR TO DISABILITY _____

MONTHLY INCOME PRIOR TO DISABILITY $_____ GROSS

$_____ NET

IF SELF EMPLOYED: NO. OF PARTNERS _____

NO. OF FULL TIME EMPLOYEES _____

NO. OF PART TIME EMPLOYEES _____

IS THE BUSINESS STILL OPERATING? ☐ NO ☐ YES, NAME OF PERSON(S) RUNNING IT? _____

HAVE YOU HIRED ANYONE TO REPLACE YOU? ☐ NO ☐ YES

OCCUPATIONAL DUTIES

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR OCCUPATIONAL DUTIES PRIOR TO ONSET OF DISABILITY:

_____

_____

_____

WHAT PERCENTAGE OF YOUR TIME IS SPENT ON THE FOLLOWING:

ADMINISTRATIVE/OFFICE _____ % MANUAL/PHYSICAL _____ %

SUPERVISORY _____ % OTHER _____ %

SALES _____ %

STRENGTH:		**YES**	**NO**	**TIMES PER DAY**	**HOURS PER DAY**
DOES YOUR OCCUPATION REQUIRE YOU TO					
A) LIFT OR CARRY:	FROM 5 - 25 POUNDS (2.5 - 11 KILOGRAMS)?	☐	☐		
	MORE THAN 25 POUNDS (11 KILOGRAMS)?	☐	☐		
B) PUSH OR PULL:	FROM 5 - 25 POUNDS (2.5 - 11 KILOGRAMS)?	☐	☐		
	MORE THAN 25 POUNDS (11 KILOGRAMS)?	☐	☐		
MOBILITY:					
DOES YOUR OCCUPATION INVOLVE:	SITTING?	☐	☐		
	STANDING?	☐	☐		
	WALKING?	☐	☐		
	CLIMBING?	☐	☐		
	DRIVING?	☐	☐		
	REMAINING IN ONE POSITION?				
	FOR MORE THAN 1 HOUR?	☐	☐		
	REACHING: ABOVE SHOULDER HEIGHT?	☐	☐		
	AT SHOULDER HEIGHT?	☐	☐		
	TWISTING?	☐	☐		
	BENDING OR CROUCHING?	☐	☐		
	KNEELING OR CRAWLING?	☐	☐		
	BALANCING?	☐	☐		

EQUIPMENT USE

LIST ANY VEHICLES, OFFICE MACHINES, TOOLS, OR OTHER EQUIPMENT WHICH YOU USE IN YOUR OCCUPATION:

TYPE OF EQUIPMENT	TIMES/DAY	HOURS/DAY

PRESENT STATUS

HAVE YOU RETURNED TO WORK?

☐ NO WHAT DATE DO YOU EXPECT TO RETURN TO WORK? PART TIME ____/____/____ (D M Y) FULL TIME ____/____/____ (D M Y)

☐ YES ____/____/____ (D M Y) ☐ FULL TIME ☐ PART TIME _____ HRS/WEEK

☐ OWN OCCUPATION ☐ ANOTHER OCCUPATION

WHICH OF YOUR OCCUPATIONAL DUTIES ARE YOU CAPABLE OF PERFORMING AT THE PRESENT TIME?

_____

_____

OTHER INSURANCE

PLEASE INDICATE IF YOU ARE ELIGIBLE TO RECEIVE ANY OTHER BENEFITS (WHETHER OR NOT YOUR CLAIM HAS BEEN APPROVED)

	EFFECTIVE DATE OF BENEFITS	**MONTHLY/WEEKLY AMOUNT**
☐ WORKER'S COMPENSATION BENEFITS		
☐ AUTOMOBILE INSURANCE COVERAGE		

PROVIDE POLICY OR CLAIM NUMBER, NAME OF AUTO INSURER, EXAMINER'S NAME, ETC.

_____

OTHER **INSURANCE POLICIES** PROVIDING A DISABILITY BENEFIT - INCLUDING SHORT AND LONG TERM DISABILITY COVERAGE - PLEASE COMPLETE SECTION BELOW.

COMPANY NAME	POLICY NUMBER	ISSUE DATE OF POLICY	EFFECTIVE DATE OF BENEFIT	BENEFIT AMOUNT	ELIMINATION PERIOD	BENEFIT PERIOD	PERSONAL	BUSINESS OVERHEAD
								☐
								☐
								☐

AUTHORIZATIONS AND DECLARATIONS

I/WE, THE UNDERSIGNED, HAVE READ, UNDERSTAND AND AGREE WITH THE CONTENTS OF THE SECTION ENTITLED "PROTECTING YOUR PERSONAL INFORMATION".

I AUTHORIZE GREAT-WEST LIFE, ANY HEALTHCARE PROVIDER, OTHER INSURANCE COMPANIES, ADMINISTRATORS OF GOVERNMENT BENEFITS, OTHER ORGANIZATIONS, OR BENEFIT SERVICE PROVIDERS WORKING WITH GREAT-WEST LIFE TO EXCHANGE PERSONAL INFORMATION, WHEN NECESSARY TO ASSESS MY CLAIM.

THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING BY ME, SUBJECT TO LEGAL AND CONTRACTUAL RESTRICTIONS, WHICH MAY APPLY. I ACKNOWLEDGE THAT I AM AWARE OF THE REASONS THE INFORMATION COVERED BY MY CONSENT IS NEEDED, AS WELL AS OF THE BENEFITS AND RISKS OF (NOT) CONSENTING.

I AGREE THAT A PHOTOCOPY OR ELECTRONIC COPY OF THIS ***AUTHORIZATIONS AND DECLARATIONS*** SECTION IS AS VALID AS THE ORIGINAL.

I DECLARE THAT THE STATEMENTS PROVIDED IN THIS INITIAL CLAIMANT'S STATEMENT AND ANY STATEMENT PROVIDED IN ANY PERSONAL OR TELEPHONE INTERVIEW CONCERNING THIS CLAIM WILL BE TRUE AND COMPLETE. I AGREE THAT ALL STATEMENTS FORM THE BASIS FOR ANY BENEFIT APPROVED AS A RESULT OF THIS CLAIM.

_____ _____

PRINT NAME SIGNATURE

_____ _____

DATE TELEPHONE NUMBER

I AUTHORIZE: HOSPITAL NAME _____ TO RELEASE ALL RECORDS CONCERNING MY HOSPITAL CONFINEMENT FROM ____/____/____ (D M Y) TO ____/____/____ (D M Y) TO THE GREAT-WEST LIFE ASSURANCE COMPANY

A COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

_____ _____

DATE SIGNATURE OF CLAIMANT

THE Great-West Life ASSURANCE COMPANY
P.O. BOX 6000
WINNIPEG, CANADA R3C 3A5

PHYSICIAN'S INITIAL STATEMENT

LIVING BENEFITS CLAIMS

NOTE TO PHYSICIAN:

IN ASSESSING A DISABILITY CLAIM, IT IS IMPORTANT TO DISTINGUISH BETWEEN THE TWO MAIN PRINCIPLES OF ***IMPAIRMENT*** AND ***DISABILITY***. AN ASSESSMENT OF ***IMPAIRMENT*** NORMALLY ENTAILS AN EXAMINATION AND DIAGNOSIS FOLLOWED BY A DETERMINATION, ON MEDICAL OR PSYCHIATRIC GROUNDS OF THE FUNCTIONS THAT THE CLAIMANT CAN OR CANNOT PERFORM. ***DISABILITY*** ON THE OTHER HAND, REQUIRES THAT THE CLAIMANT'S ***IMPAIRMENT*** BE ASSESSED IN CONJUNCTION WITH HIS/HER JOB DESCRIPTION, THE WORDING OF HIS/HER POLICY AND PERSONAL FACTORS SUCH AS EDUCATION, TRAINING, EXPERIENCE, ETC.

THE DETERMINATION OF ***DISABILITY*** WILL BE MADE BY GREAT-WEST LIFE. HOWEVER, TO ASSIST US IN THIS DETERMINATION, WE WOULD APPRECIATE IT IF YOU COULD PROVIDE US WITH A REPORT REGARDING THE ***IMPAIRMENT*** OF THIS CLAIMANT.

NAME OF CLAIMANT DATE OF BIRTH

I HEREBY AUTHORIZE THE RELEASE TO THE GREAT-WEST LIFE ASSURANCE COMPANY OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CLAIM.

_____ _____
DATE SIGNATURE OF CLAIMANT

1. DIAGNOSIS

A. PRESENT MEDICAL IMPAIRMENTS IN ORDER OF IMPORTANCE.

_____

_____

B. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED? _____/_____/_____ (D M Y)

C. OBJECTIVE MEDICAL FINDINGS INCLUDING RESULTS OF ALL DIAGNOSTIC TESTS AND X-RAYS. (PLEASE INCLUDE COPIES IF PREFERRED.)

_____

_____

D. SPECIFICALLY, HOW DOES THE CLAIMANT'S PHYSICAL AND/OR MENTAL IMPAIRMENT(S) AFFECT HIS/HER ABILITIES?

_____

_____

_____

_____

E. IF THE IMPAIRMENT IS DUE TO PREGNANCY, WHAT IS THE EXPECTED DUE DATE? _____/_____/_____ (D M Y)
PLEASE INCLUDE A PHOTOCOPY OF THE PRENATAL RECORD.

2. TREATMENT

A. DATE OF FIRST VISIT. _____/_____/_____ (D M Y)

B. DATE OF LATEST VISIT. _____/_____/_____ (D M Y)

C. FREQUENCY: ☐ WEEKLY ☐ MONTHLY ☐ OTHER _____

D. WHAT IS THE NATURE AND FREQUENCY OF CURRENT TREATMENT (INCLUDING MEDICATIONS AND DOSAGES; TYPE AND FREQUENCY OF THERAPY; SURGERY PERFORMED OR CONTEMPLATED)?

_____

_____

_____

_____

E. IF A SPECIALIST'S REFERRAL HAS BEEN MADE, PLEASE PROVIDE NAME AND DATE OF FIRST CONSULTATION.

_____

_____

PLEASE INCLUDE COPIES OF ALL CONSULTATION REPORTS.

3. CURRENT MEDICAL STATUS

A. HAS THE CLAIMANT'S CONDITION IMPROVED? IF YES, TO WHAT DEGREE?

B. HAS THE CLAIMANT RETURNED TO WORK? ☐ NO

☐ YES _____/_____/_____ (D M Y) ☐ PART TIME ☐ FULL TIME

C. IF THE CLAIMANT HAS NOT RETURNED TO WORK WE WOULD APPRECIATE ANY ADDITIONAL INFORMATION YOU CAN PROVIDE THAT WILL ASSIST US IN OUR CONTINUING ASSESSMENT OF THIS CLAIM.

4. REHABILITATION

A. IS THE CLAIMANT A SUITABLE CANDIDATE FOR TRIAL EMPLOYMENT?

- FOR HIS JOB? ☐ YES ☐ NO
- FOR ANY OTHER WORK? ☐ YES ☐ NO

B. WHEN COULD TRIAL EMPLOYMENT COMMENCE?

- CLAIMANT'S JOB _____/_____/_____ (D M Y) ☐ FULL TIME ☐ PART TIME
- ANY OTHER WORK ____/_____/_____ (D M Y) ☐ FULL TIME ☐ PART TIME

C. IS THE CLAIMANT A SUITABLE CANDIDATE FOR A VOCATIONAL REHABILITATION PROGRAM? ☐ YES ☐ NO

PHYSICIAN'S NAME (PLEASE PRINT)

ADDRESS

POSTAL CODE _____

TELEPHONE: ( ) _____

SIGNATURE

DATE