# Individual disability claim

This document outlines the requirements to apply for your individual disability benefits and your life disability benefits.

## Step 1: Claimant's initial statement and consent form

- Complete the *Claimant's initial statement* (form **K891**).[1] If additional space is required, write on a separate page.
- The completed claimant's initial statement provides us with notice of your disability claim. It also provides us with general information about you, your occupation and your health.

## Step 2: Physician's initial statement

- Have your doctor complete the *Physician's initial statement* (form **70-0719**) located at canadalife.com.[2]
- To avoid delays with the review of your claim we recommend that you include copies of all relevant medical records with the physician's initial statement, such as chart notes, consultation reports and test results.
- The completed physician's initial statement provides us with information regarding your medical condition and treatment plan.
- Your doctor can mail, email or fax the completed physician's initial statement directly to The Canada Life Assurance Company (Canada Life) at the contact information below.

## Contact information

The Canada Life Assurance Company
Living Benefits Claims
PO Box 6000, Winnipeg MB  R3C 3A5

Email: lbclaims@canadalife.com
Fax: 1-204-946-4030
Toll-free: 1-877-280-7527
Visit canadalife.com

## Our responsibility

The review of your claim will begin when we receive your *Claimant's initial statement* and *Physician's initial statement*.

Once we receive the claimant's initial statement, we will send you an acknowledgment letter or email which will provide you with your claim specialist's name and contact information. Your claim specialist will contact you within 10 business days from having received the claimant's initial statement to let you know what you can expect throughout the claim process and to obtain any further information that may be required.

## Email disclaimer

The protection of confidential client information is very important to our organization. Email, although very convenient, is not a secure medium for the exchange of confidential personal information. We cannot guarantee the security of correspondence via email. If you wish to receive correspondence by email, please note that we can take no responsibility for ensuring that the information will remain confidential and not be intercepted or read by others, either over the internet or through the receiving computer. By giving us your email address in 1.7, you acknowledge and agree that you are aware of the risk and are accepting this risk.

## Protecting your personal information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life, or the offices of an organization authorized by Canada Life. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada 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 collect, store, use and disclose the personal information to investigate and assess your claims with Canada Life. For a copy of our Privacy Guidelines or if you have any questions about our personal information policies and practices (including with respect to service providers), write to Canada Life Chief Compliance Officer or refer to canadalife.com.

1 In providing any claim forms, Canada Life does not admit any liability or waive any of its rights.
2 You are responsible for any fees related to the completion of the forms and any other medical information provided.

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# Claimant's initial statement

## Individual disability claim

The Canada Life Assurance Company
Living Benefits Claims
PO Box 6000, Winnipeg MB R3C 3A5

Toll-free: 1-877-280-7527
Email: lbclaims@canadalife.com
Fax: 1-204-946-4030

## 1. Insured's information

**1.1** Policy numbers: _____

**1.2** Name of insured: _____

**1.3** Date of birth (day/month/year): _____

**1.4** Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

**1.5** Phone number: _____

**1.6** Do you prefer your communication to be sent by email? ☐ Yes ☐ No

**1.7** Email address (optional): _____

See *Email disclaimer*.

## 2. Claim details

**2.1** Claiming benefits from (day/month/year): _____ to (day/month/year): _____

**2.2** Are you currently working in any capacity?

☐ Yes, return to work date (day/month/year): _____

If you are working reduced hours or performing modified duties, provide details:

_____

☐ No, last day of work (day/month/year): _____

When do you expect to return to work (day/month/year): _____ **or** ☐ Unknown

**2.3** Is your condition the result of an accident? ☐ Yes, provide details below ☐ No

Date of accident (day/month/year): _____

Details of the accident: _____

Is your condition work related? ☐ Yes ☐ No

Was it a motor vehicle accident? ☐ Yes, in what province did your accident occur: _____ ☐ No

**2.4** What medical conditions are impacting your ability to work:

_____

**2.5** When did the signs and symptoms for your condition first appear (day/month/year): _____

**2.6** Have you had same or similar signs or symptoms in the past?

☐ Yes, when (day/month/year): _____ ☐ No

**2.7** Are you: ☐ Right-handed **or** ☐ Left-handed

**2.8** Height: _____ feet _____ inches, **or** _____ centimetres

Weight: _____ pounds, **or** _____ kilograms

**2.9** Were you admitted to a hospital? ☐ Yes, provide details below ☐ No

Name of hospital: _____

Date admitted (day/month/year): _____

Date discharged (day/month/year): _____ **or** ☐ Still hospitalized

**2.10** Have you had surgery since being off work or is surgery planned? ☐ Yes, provide details below ☐ No

Date of surgery(day/month/year): _____

Type of surgery: _____

**2.11** Are you currently receiving any other forms of treatment (physiotherapy, psychotherapy, etc.)?

☐ Yes, provide details: _____

☐ No

**2.12** Provide details of any future treatment, upcoming consultations and tests.

_____

**2.13** Provide the following information of your health care providers related to this claim.

Primary physician: _____

Specialty: _____

Address: _____

Email address: _____

Phone number: _____ Fax number: _____

Date of first consultation (day/month/year): _____

Date of last consultation (day/month/year): _____

Date of next consultation (day/month/year): _____

Other care provider: _____

Specialty: _____

Address: _____

Email address: _____

Phone number: _____ Fax number: _____

Date of first consultation (day/month/year): _____

Date of last consultation (day/month/year): _____

Date of next consultation (day/month/year): _____

Other care provider: _____

Specialty: _____

Address: _____

Email address: _____

Phone number: _____ Fax number: _____

Date of first consultation (day/month/year): _____

Date of last consultation (day/month/year): _____

Date of next consultation (day/month/year): _____

## 3. Employment information prior to disability

**3.1** Company or business name: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Website: _____

**3.2** Job title: _____

Nature of business: _____

**3.3** How long have you been working at your current occupation: _____

**3.4** How many hours per week did you normally work prior to your disability: _____

**3.5** Specify your daily work schedule (for example, 8 a.m. to 4 p.m.)

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

If your work schedule varies, provide details: _____

**3.6** Is your occupation seasonal? ☐ Yes ☐ No

**3.7** Do you have more than one occupation? ☐ Yes ☐ No

**3.8** Provide a detailed description of your occupational duties prior to your disability. Attach a job description if available.

_____

**3.9** What percentage of your time was spent on the following duties, total must add up to 100%.

Administrative or office: _____ %

Manual or physical: _____ %

Supervisory: _____ %

Sales: _____ %

Other, provide percent and details: _____ % _____

**3.10** Are you: ☐ Self-employed ☐ Employee ☐ Unemployed ☐ Retired

If self-employed, answer the following questions:

Is your business: ☐ Incorporated ☐ Unincorporated

What is your percentage of ownership: _____ %

Number of full-time employees, other than you: _____

Number of part-time employees: _____

Number of business partners, other than you: _____

Is your business still operating? ☐ Yes ☐ No

Have you hired someone to replace you? ☐ Yes ☐ No

## 4. Other information

**4.1** Have you applied for, are you receiving, or are you eligible for any other benefits as a result of your disability?

☐ Yes, provide details below ☐ No

| Select all that apply | Policy or claim number | Case manager name and phone number |
|---|---|---|
| ☐ **Canada Pension Disability Plan or Quebec Pension Disability Plan** | | |
| ☐ **Worker's Compensation Board benefits (or similar benefits)** | | |
| ☐ **Automobile accident benefits** | | |
| ☐ **Employment insurance benefits** | | |
| ☐ **Group disability insurance (STD or LTD benefits)** | | |
| ☐ **Other individual disability insurance** | | |
| ☐ **Individual life insurance** | | |
| ☐ **Creditor or loan insurance** | | |
| ☐ **Critical illness insurance** | | |
| ☐ **Business overhead insurance** | | |

## 5. Direct deposit

**Optional:** Should your policy and claim be eligible for monthly disability benefits and you wish for these payments to be deposited directly into your bank account, please provide your banking information, or attach a void cheque.

This option may not be available to all life disability benefits.

Name of financial institution: _____

Transit number: _____ Bank code: _____ Account number: _____

## 6. Your consent

Before we can process your claim for benefits, you must read this agreement and provide a handwritten signature in the box below.

### Sharing your personal information

**We collect, use and disclose your personal information to:**

- Investigate and assess your claim
- Administer your claim
- Audit the assessment of the claim

**We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:**

- Healthcare and rehabilitation providers
- Independent medical specialist
- Insurance and reinsurance companies
- Administrators of government benefits and of other benefit programs
- Any person having knowledge of you or your health
- Other organizations or service providers working with us
- **Optional:** Insurance advisor associated with this policy. If you agree, please provide the advisor's name and contact information.

  Name of advisor: _____

  Phone number or email address: _____

### Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. This information about you may include medical and psychiatric information. Canada Life may use service providers located within or outside Canada. The only persons with access to the information are:

- People working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim
- Those whom you've given access
- Those authorized by law both within Canada and in any other jurisdiction where your personal information is held

### By signing below, you confirm that:

- You have read, understand, and agree with the contents of this form and authorize us to collect and disclose your personal information.
- Subject to legal and contractual restrictions, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete.
- A photocopy or electronic copy of this authorization is as valid as the original.

Date signed (day/month/year): _____

Name of insured: _____

Phone number: _____

Policy numbers: _____

X _____

Signature of **insured**