Short-term Disability Program

Application kit

OVERVIEW

The Short-term Disability Program (STDP) ensures consistent treatment for all employees who are absent from work due to an illness or a non-work related accident. It provides coverage to all eligible employees regardless of their medical history or how long they have been with Canada Post. It exists to:

- ensure employees receive the right support at the right time;
- encourage a healthy, timely and safe return to work;
- assess early accommodation potential; and
- reduce the financial impact of a workplace absence.

Canada Post is committed to finding safe and suitable work for your return, including modified duties where applicable.

ELIGIBILITY

Those who meet eligibility requirements will receive STDP benefits if deemed: ill for more than seven calendar days; had a non-work related accident; or hospitalized. If you are unsure if you are eligible, ask your team leader or refer to STDP Central on Intrapost.

FORMS

Attending Physician's Statement and *Employee Statement*. You are responsible for any costs related to the completion of the *Attending Physician's Statement*. Send by mail, email or fax to the address indicated on the forms.
For Management (MGT) employees, the forms must be received by the disability management provider within seven calendar days of the start of your absence, or your pay may be interrupted. Any period of time paid as pending that is not supported will be recovered.

For APOC, PSAC, CPAA, CUPW Urban and CUPW RSMC represented employees, if the forms are not received by the disability management provider within 16 cleandar days of the start of your absence, your pay will be interrupted.
Any period of time paid as pending that is not supported will be recovered.

ASSESSMENT OF CLAIMS

To receive benefits under the STDP, your claim must be supported by the disability management provider. Information provided by the treating physician must demonstrate that you are unable to work as a result of your illness or accident.*

To continue to receive benefits, you must be under the care of a physician or other regulated health care professional and follow an appropriate treatment program.

EMPLOYEE RESPONSIBILITIES

Throughout your claim, you must continue to provide satisfactory proof of your continued total disability, actively participate in the disability-management program, keep your team leader and case manager informed, and accept appropriate accommodations.

* *Privacy:* Disability management services providers retained by Canada Post are contractually bound to protect the privacy our employees, to treat all medical information collected as confidential, and to protect such information from improper and unauthorized use and disclosure.

Short-term Disability Program

Application kit

- Unable to work because of illness lasting **more than seven calendar days?**
- Recovering from a non-work related accident?
- Are you hospitalized?

Five things you need to do as per the STDP application process

1

☐ **REPORT** to your team leader immediately.

2

☐ **CALL** the disability management provider, **24 hours after** informing your team leader, to book an initial telephone assessment with a case manager. The number is **1-855-554-3148**. They are open Monday to Friday, 5:30 am to 8 pm ET.

3

☐ **OBTAIN** an **STDP Application on Intrapost (ESS, STDP Central), from your team leader or on canadapost.ca (I'm an Employee).** The kit contains the two required forms you will need: **Attending Physician's Statement** and **Employee Statement.**

4

☐ **VISIT** your physician and **ensure the Attending Physician's Statement form is completed.**

5

☐ **SUBMIT** the completed *Attending Physician's Statement* and *Employee Statement* forms to the disability management provider.

MGT employees: The forms must be received within seven calendar days of the start of yourabsence, or your pay may be interrupted.

APOC, PSAC, CPAA, CUPW Urban and CUPW RSMC represented employees: The forms must be received within 16 calendar days of the start of your absence, or your pay will be interrupted.

Remember, it is critical to seek medical attention quickly, follow the treatment plan prescribed and keep your case manager and team leader informed.

ATTENDING PHYSICIAN'S STATEMENT

Short-term Disability Claim

Please complete this form as soon as possible with all relevant information to expedite the processing of your patient's claim for disability benefits under the Canada Post Short-term Disability Program. Complete and return this form to **the Disability Management Provider. MGT employees: The form must be received within seven calendar days from the beginning of their absence to avoid pay interruptions.**

APOC, PSAC, CPAA, CUPW Urban and CUPW RSMC represented employees: The form must be received within 16 calendar days of the beginning of their absence, or their pay will be interrupted.

The completed form should be mailed, emailed or faxed directly to:

Canada Life/TELUS Health
895 Don Mills Rd Tower One Suite 700
Toronto ON M3C 1W3
Fax: 1-877-562-9126
Email: admdocuments@telushealth.com

This form is not to be used for workplace injuries / illnesses.

SECTION A To be completed by patient (please print)

Employee name (Last, First, Middle initial):		
Employee ID number:	Email:	
Home phone number:	Other phone number:	
Date of birth (dd/mm/yyyy):	Bargaining agent (if applicable):	Date form provided to physician (dd/mm/yyyy):

I hereby authorize the release of information held in my file by the physician named below to the **Disability Management Provider** and its agents and service providers for the purpose of assessing my claim and administering the disability plan regarding this claim. This medical information includes, but is not limited to, copies of consultation reports, clinical notes, test results and hospital records supporting this claim. **I understand that I am responsible for any costs related to the completion of this form.**

Employee's signature:	Date (dd/mm/yyyy):

SECTION B To be completed by the attending physician or health care professional (please print)

Diagnosis(es) or working diagnosis(es):	
If psychological, please provide DSM V Axis 1 diagnosis. Primary diagnosis:	Secondary diagnosis:
GAF score (if applicable):	If patient is pregnant, expected or actual delivery date (dd/mm/yyyy):
Is the diagnosed disability the result of: a non-occupational illness? ☐ a non-occupational accident? ☐	
Has the patient had a similar or related condition? No ☐ Yes ☐ If yes, state when and describe condition:	Is the condition considered to be chronic? No ☐ Yes ☐ If yes, what precipitated the absence from work?
Date of first visit for current disability (dd/mm/yyyy): Date of last visit for current disability (dd/mm/yyyy):	Date first unable to work due to current disability (dd/mm/yyyy): Expected date of return to work (dd/mm/yyyy):

Admitted to hospital (inpatient or outpatient)? No ☐ Yes ☐		Date admitted (dd/mm/yyyy):
Hospital department / ward admitted to:		Date discharged (dd/mm/yyyy):

Treatment (current medication, types of drug(s), dosage and duration, physiotherapy, other):

SECTION C Physician's / Health care professional's acknowledgement and authorization (please print)

I acknowledge that the information in this statement will be kept in a health file with the Disability Management Provider and may be accessed by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Address (number, street, city, province, postal code):	
Telephone number:	Fax number:
Signature:	Date signed (dd/mm/yyyy):

NOTE TO PHYSICIAN / HEALTH CARE PROFESSIONAL: If the disability is anticipated to be resolved within two weeks of its onset, no further information is required. If not, please complete section D.

SECTION D Additional information for absences known / expected to exceed two weeks (please print)

Describe the patient's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living.

Frequency of visits: Weekly ☐ Monthly ☐ Other ☐	Patient's height:	Patient's weight:
Is complete recovery expected? No ☐ Yes ☐	Expected recovery date:	

Describe any factors that may affect this patient's ability to return to work:

Attach copies of all relevant test results / investigations and consultation reports. If test results are not attached, it will be assumed that tests were not performed. If a consultation report is not attached, indicate if your patient has or will be seen by a specialist for this condition.

Name of specialist:	Specialty	Date of visit:
Name of specialist:	Specialty	Date of visit:

List any complications and additional condition(s) impacting your patient's level of function or the expected recovery period.

Physical impairment Does your patient have a physical impairment? **No** ☐ **Yes** ☐ If yes, complete this section.

Based on your assessment, describe your patient's current abilities in the following areas:

Lifting (max. weight / frequency)		Standing (duration / frequency)	
Carrying (max. weight / distance)		Walking (distance / frequency)	
Pushing / Pulling (max. weight / frequency)		Climbing (duration / frequency)	
Walking on uneven ground (distance / frequency)		Crawling (duration / frequency)	
Working at heights (height / frequency)		Keying / Typing (duration / frequency)	
Sitting (duration / frequency)		Mousing (duration / frequency)	

Remarks:

Cognitive / Mental impairment Does your patient have a cognitive / mental limitation? No ☐ Yes ☐ If yes, complete this section.

Indicate if patient currently has cognitive / mental restrictions in the following areas:	None	Mild	Moderate	Severe
Concentration (ex.: attention, orientation)				
Analytical reasoning (ex.: judgment)				
Learning new material (ex.: memory)				
Comprehension				
Social interaction (ex.: mood)				
Ability to multi-task				

In your opinion, is your patient competent to manage his / her own affairs? No ☐ Yes ☐

Remarks:

Rehabilitation / Work re-entry Has your patient expressed any concerns related to returning to work? No ☐ Yes ☐
Describe:

Expected date of return to work to full duties (dd/mm/yyyy):

Provide details about return-to-work plans for the patient:

To your knowledge, is the patient following the recommended treatment program? No ☐ Yes ☐

Has your patient's professional licence certification, driver's or other licence been restricted, suspended or revoked? No ☐ Yes ☐

Physician / Health care professional signature:	Title / Profession:	Date signed (dd/mm/yyyy):

EMPLOYEE STATEMENT
Short-term Disability Claim

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for disability benefits under the Canada Post Short-term Disability Program. Complete and return this form to the Disability Management Provider. MGT employees: The form must be received within seven calendar days from the beginning of their absence to avoid pay interruptions.

APOC, PSAC, CPAA, CUPW Urban and CUPW RSMC represented employees: The form must be received within 16 calendar days of the beginning of their absence, or their pay will be interrupted.

The completed form should be mailed, emailed or faxed directly to:

Canada Life/TELUS Health
895 Don Mills Rd Tower One Suite 700
Toronto ON M3C 1W3
Fax: 1-877-562-9126
Email: admdocuments@telushealth.com

This form is not to be used for workplace injuries / illnesses. Ask your team leader instead to provide you with the appropriate WCB form.

SECTION A Employee information (please print)

Employee name (last, first, middle initial):

Employee ID number:	Email:
Home phone number:	Other phone number:

Full address (street, city, province, postal code):

Date of birth (dd/mm/yyyy):

SECTION B Information about your work (please print)

Last day worked (dd/mm/yyyy):	Full-time ☐ Part-time ☐ Term employee greater than 6 months ☐
First day of absence (dd/mm/yyyy):	Team leader's name:
Expected return to work:	Team leader's telephone number:

Job title:

Do you: Work alone ☐ Supervise others ☐ Interact with public ☐ Drive / operate machinery ☐

Describe your job duties:

SECTION C Information about your claim (please print)

Is your disability the result of: a non-work related illness? ☐ a non-work related accident? ☐ a motor vehicle accident? ☐

Describe how your illness / injury is affecting your abilities:

Have you had a similar or related condition? No ☐ Yes ☐ If yes, how long ago?

Do you feel capable to return to work if modified work is available? No ☐ Yes ☐

Date and time of accident (if applicable):	Are you seeking reimbursement from a third party? No ☐ Yes ☐

Briefly describe how and where the accident happened:

Were you hospitalized or admitted to a clinic (inpatient or outpatient)? No ☐ Yes ☐	Date admitted (dd/mm/yyyy):	Name of institution:
Name of ward / unit:		Date discharged (dd/mm/yyyy):

SECTION D Income or benefit Information (please print)

Income / Benefit information
Have you applied for or are you receiving any of the following:

	Start date	End date	Amount (indicate weekly or monthly)
Employment insurance*			
Benefits payable under any type of Worker's Compensation Board program (WCB / WSIB / CSST)			
Benefits payable from motor vehicle insurance or other insurance (e.g. SAAQ, MPI, SGI, ICBC, etc.)			
Earnings from other employment (where employment started after last day worked at Canada Post)			

Note: For the duration of your claim, it is your responsibility to notify the disability provider of any work performed, whether or not you have received any wage or remuneration. The information in Section D will be provided to Canada Post for the purpose of calculating your benefit.

It is also your responsibility to notify AccessHR of any earnings received from a third party throughout your STDP claim. Once received, send a copy of the official pay statement and letter from the third party to:
Canada Post AccessHR
STDP Transaction Centre
2701 Riverside Drive Suite B0310
Ottawa ON K1A 0B1

Canada Post will recover the equivalent of your third-party payments from your Canada Post earnings at a rate of **100%** of your gross biweekly pay until the full amount is recovered. *For CUPW Urban and CUPW RSMC, Employment Insurance recoveries will be at a rate of 10% of your gross biweekly pay until the full amount is recovered.

SECTION E Information about your physician / health care professional(s)

Name of primary attending physician / health care professional:

Physician's / health care professional's speciality (if applicable):	Date of first treatment for current disability:
Address	Telephone number:

Are you following the recommended treatment program? No ☐ Yes ☐

SECTION F

If your claim is approved as an "illness claim", personal days then top-up credits will be used automatically to cover the waiting period, where available. If you have insufficient personal days or top-up credits to cover the waiting period, you will be given the option to use annual (vacation) leave or compensatory leave; if you choose neither , any remaining time in the waiting period will be coded as "STDP Unpaid Pensionable." Indicate your choice below.

Annual leave (where applicable)	Compensatory Leave (where applicable)
No ☐ Yes ☐ I'll decide later ☐	No ☐ Yes ☐ I'll decide later ☐
First Priority: Annual leave ☐ Compensatory leave ☐	

Canada Post is subject to the Privacy Act and is committed to protecting employee personal information and managing this information with utmost responsibility and care. You can be sure that any medical information you give to our disability-management providers will be kept strictly confidential and protected from improper and unauthorized use, disclosure, retention and disposal.

I certify that the information on this form is true and complete, to the best of my knowledge. I understand that my claim may be denied or terminated as a result of my providing false or misleading information or omitting pertinent information.

I authorize my attending physician / health care professional, the disability management provider and its agents and service providers and any person or organization who has relevant personal information about me, including health care professionals and organizations, to exchange information for the purpose of determining eligibility for and the adjudication of my claim. This includes the release of any related medical information, including but not limited, to copies of all consultation reports, clinical notes, test results and hospital records.

I authorize the disability management provider and Canada Post to exchange information about me, except for details relating to diagnosis, treatment or medication relevant to this claim, for the purpose of planning and managing my return to work and for administering the Short-term Disability Program.

I agree that a photocopy of this authorization shall be as valid as the original.

Employee's signature:	Date (dd/mm/yyyy):

NOTE: In the event of an overpayment, Canada Post will recover excess amounts paid.