Group Life & Health

Disability claim form – initial assessment

STANDARD LIFE

NOTE : In order to ensure confidentiality of personal information, Standard Life will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Standard Life responsible for the management of your claim shall have access to the file.

Instructions for:

A. The participant:

1. Please complete the "Participant statement" section.
2. Please ensure that the policyholder completes the "Policyholder statement" section.
3. Please ensure that your physician completes the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other conditions. As well, please provide your physician with a copy of your completed Participant statement so that the physician will have your signed authorization to release information to The Standard Life Assurance Company of Canada.
4. Please note that any costs incurred in the completion of the "Attending physician statement" are your responsibility.
5. Please ensure that all of the above-mentioned forms are submitted to Standard Life on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.
6. Please complete the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Standard Life. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

B. The policyholder

1. Please complete the "Policyholder statement" section.
2. In order to avoid unnecessary delays in the processing of Long-Term Disability claims (without Short-Term Disability), we ask that these forms be completed and sent to Standard Life as follows.

   For policies with an elimination period of:

   - 90 days, completed forms should be sent to us as of the 50th day of absence.
   - 105 days, completed forms should be sent to us as of the 60th day of absence.
   - 120 days, completed forms should be sent to us as of the 75th day of absence.
   - 17 weeks, completed forms should be sent to us as of the 11th week of absence.
   - 26 weeks, completed forms should be sent to us as of the 20th week of absence.

C. The physician:

1. Please complete the appropriate "Attending physician statement", depending on the nature of the primary diagnosis.

Direct deposit authorization

Policy no.	Certificate no.	Participant surname	Given name(s)	Initial

Financial institution name	Financial institution address

Type of bank account: ☐ Chequing ☐ Savings

Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

Direct deposit:	Branch no.	Institution no.	Account no.

I authorize Standard Life to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Standard Life of any subsequent changes. I accept that this agreement may be cancelled at any time by either Standard Life or myself, in writing or verbally.

Participant signature	Date *(YYYY/MM/DD)*

Account holder signature *(if other than participant)*	Date *(YYYY/MM/DD)*

GE10342H-03-2010 GL

Group Life & Health

Disability claim form – initial assessment

Disability claims department

Montréal
P.O. Box 4002 STN B
Montréal, Québec H3B 4M2

Toronto
P.O. Box 4105 STN A
Toronto, Ontario M5W 2P4

Calgary
P.O. Box 1315 STN M
Calgary, Alberta T2P 2L2

Fax: 1-866-645-4180

Please keep the original documents faxed to Standard Life.

Participant statement

To be completed by the participant. Please note that all questions must be answered in as much detail as possible.

Section A – General information

☐ Mr. ☐ Mrs. ☐ Ms. Gender: ☐ Male ☐ Fémale | Date of birth *(YYYY/MM/DD)* | Policy no. | Certificate no.

Surname | Given name(s) | Initial | Social insurance number

Address *(no., street)*

City | Province | Postal code | Telephone no. | Language: ☐ English ☐ French

Name of employer **(and division if different)** | Occupation **(just prior to last day worked)** | Original date of hire *(YYYY/MM/DD)*

Tax exempt ☐ Yes ☐ No If Yes, please state reason

Other current employer ☐ Yes ☐ No If Yes, please name.

Section B – Claim information

Was the reason you stopped working due to:
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident *(not while working)* ☐ Occupational illness or work accident
(If the reason was a motor vehicle accident, please submit a police or collision report, except in Québec.)

If you have suffered an injury, please describe how, when, and where the injury occurred.

What was the last day you worked? *(YYYY/MM/DD)* | Were you performing: ☐ Your regular duties ☐ Modified duties | Was this a full day? ☐ Yes ☐ No | If No, how many hours did you work on your last day?

What was the date you were first unable to work? *(YYYY/MM/DD)* | When did you first notice these symptoms? *(YYYY/MM/DD)* | When were you first treated by a physician? *(YYYY/MM/DD)*

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? ☐ Yes ☐ No

If Yes, please provide the dates and name(s) of physicians who treated you at the time.

Please describe the major duties of your occupation.

Please describe why you are unable to perform the duties of your occupation.

Do you have an expected date of return to work? ☐ Yes ☐ No If Yes, please provide the date *(YYYY/MM/DD)*

GE10342H-03-2010 GL

Disability claim form – initial assessment

STANDARD LIFE

Participant statement *(continued)*

Section C – Health care professional information

Please list all of the health care professionals you have consulted in the last 12 months, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name		Consulted from	*(YYYY/MM/DD)*	to	*(YYYY/MM/DD)*
Address *(no., street)*					
Telephone no.	Fax no.	Specialty			
Name		Consulted from	*(YYYY/MM/DD)*	to	*(YYYY/MM/DD)*
Address *(no., street)*					
Telephone no.	Fax no.	Specialty			
Name		Consulted from	*(YYYY/MM/DD)*	to	*(YYYY/MM/DD)*
Address *(no., street)*					
Telephone no.	Fax no.	Specialty			

Section D – Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable:

Source	Claim no., contact name, telephone no.	Have you applied?		Are you receiving payment?			Monthly Amount
		Yes	No	Yes	No	Pending	
Worker's Comp / CSST		☐	☐	☐	☐	☐	
Canada Pension Plan - Disability		☐	☐	☐	☐	☐	
Canada Pension Plan - Retirement		☐	☐	☐	☐	☐	
Québec Pension Plan (QPP) - Disability		☐	☐	☐	☐	☐	
Québec Pension Plan (QPP) - Retirement		☐	☐	☐	☐	☐	
Employment Insurance		☐	☐	☐	☐	☐	
Auto Insurance		☐	☐	☐	☐	☐	
Other Insurer		☐	☐	☐	☐	☐	

Section E – Participant authorization and declaration

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Standard Life, permitting the assessment of my claim.

I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life and/or their authorized agents will use the information provided in this form and in my pertinent prior claims under the same plan for the management of my claim and for production of statistical reports.

I consent to the use of my social insurance number as my membership number under the plan as an identifier in Standard Life's database, and that it is my responsibility to contact my employer if I prefer to use another identification number.

I certify that the information contained in this form is true and complete.

A photocopy of this authorization is valid as the original..

Name *(please print)*	Signature
Policy no.	Date *(YYYY/MM/DD)*