

Disability claim form

Initial assessment

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: <input type="checkbox"/> Chequing <input type="checkbox"/> 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.	
Participant signature			Date (YYYY/MM/DD)	
Account holder signature (if other than participant)			Date (YYYY/MM/DD)	

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.



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
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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

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	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: <input type="checkbox"/> English <input type="checkbox"/> French
Name of employer (and division if different)		Occupation (just prior to last day worked)		Original date of hire (YYYY/MM/DD)
Tax exempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please state reason		
Other current employer	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Your regular duties <input type="checkbox"/> Modified duties	Was this a full day? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please provide the date (YYYY/MM/DD)
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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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan - Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan - Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Québec Pension Plan (QPP) - Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Québec Pension Plan (QPP) - Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auto Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Insurer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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)



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
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Please keep the original documents faxed to Standard Life.

Policyholder statement
To be completed by the policyholder. All questions must be answered in as much detail as possible.

Section A – Policyholder information

Name of policyholder (Employer/Union/Association)	Name of subsidiary or division (if different)
Address (no., street)	

Section B – Participant information

Surname	Given name(s)	Initiale
Policy no.	Division no.	Class no.
Social insurance number	Certificate no.	Permanent employee? <input type="checkbox"/> Yes <input type="checkbox"/> No
Nature of request for benefits: <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Waiver of premiums <input type="checkbox"/> Dismemberment		
Was the employee actively at work when the absence began / loss occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide the date on which this participant was first covered under this policy: (YYYY/MM/DD)		
If No, please comment.		
What was the participant's date of hire? (YYYY/MM/DD)		last date of work? (YYYY/MM/DD)
If already back at work, what was the start date? <input type="checkbox"/> Part-time (YYYY/MM/DD) <input type="checkbox"/> Full-time (YYYY/MM/DD)		
What was the participant's main reason for absence: <input type="checkbox"/> Illness <input type="checkbox"/> Injury away from work <input type="checkbox"/> Motor vehicle accident (not while working) <input type="checkbox"/> Occupational illness or work accident		
Please indicate the hours of work in a normal week: Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____ (If shift work, please provide work schedule)		
What was the participant's gross weekly salary as of his/her last day of work? \$ _____		Was the participant: <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
Personal income tax exemptions: Federal \$ _____ Provincial \$ _____		Personal income tax claim/deduction code: Federal _____ Provincial _____
Did the participant receive any income during the disability period? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please select one of the following: <input type="checkbox"/> Vacation <input type="checkbox"/> Maternity leave <input type="checkbox"/> Employment insurance <input type="checkbox"/> Sick days <input type="checkbox"/> Statutory holidays <input type="checkbox"/> Other _____		
Amount \$ _____ From (YYYY/MM/DD)		to (YYYY/MM/DD)
Has the participant submitted a claim to the following government bodies? <input type="checkbox"/> WSIB / WCB / CSST <input type="checkbox"/> EI <input type="checkbox"/> CPP <input type="checkbox"/> QPP (RRQ) <input type="checkbox"/> Provincial automobile insurance board		

Policyholder statement (continued)

Section C – Occupational information

What was the participant’s regular occupation immediately prior to his/her stopping work?

Were the participant’s duties modified from his/her regular occupation? Yes No

Please describe this employee’s regular occupation (or attach a copy of the company’s job description) as well as any modifications, if any.

The following physical demands analysis of the participant’s occupation is to be completed by his/her supervisor.
In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

I) at any one time without a break (approximately) **and**;
II) in total throughout the day (approximately)

Physical demands analysis		I	II
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down the stairs			
6. Lifting	0 - 10 pounds <input type="checkbox"/> 10 - 20 pounds <input type="checkbox"/> 20 - 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/> with lifting device? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Pushing/Pulling	0 - 10 pounds <input type="checkbox"/> 10 - 20 pounds <input type="checkbox"/> 20 - 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/>		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.)

Does the participant wear personal protective equipment (i.e. safety glasses/footwear, respiratory protection, ear protection, etc.)?
If Yes, please describe.

I certify that the information given above is true and complete.

Date (YYYY/MM/DD)

Name (please print)

Telephone no.

Signature of the authorized person

Job title



Disability claims department

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Attending physician’s statement (Physical conditions)

In order for the employer or its agents to properly assess your patient’s claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Surname	Given name(s)	Initial
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occurred? (YYYY/MM/DD)

What was the date of the patient’s first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient’s first visit during the present period of absence from work? (YYYY/MM/DD)

If the patient has a cardiac condition, what is his/her current functional capacity based on the American Heart Association classifications:

Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Severe Limitation)

What is the patient’s blood pressure? (YYYY/MM/DD)

Current _____ Previous _____

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed? Yes No

If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? Yes No

If Yes, please elaborate.

Please provide a complete list of the patient’s symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What are the patient’s current limitations (things that he/she cannot do)? Please be specific.

What are the patient’s current restrictions (things that he/she should not do)? Please be specific.

Is your patient competent to manage his/her own financial affairs? Yes No

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

If a potential return to work date has been discussed, please provide the date. (YYYY/MM/DD)

Attending physician’s statement (Physical conditions) (continued)

Has the patient ever had the same or similar condition? Yes No
 If Yes, please provide dates and describe.

Is the patient’s condition due to injury or sickness arising out of his/her employment? Yes NO
 If Yes, please elaborate.

If the patient was/is pregnant, please indicate the date or expected date of confinement. (YYYY/MM/DD)

Section C – Treatment

Frequency of patient visits:
 Weekly Bi-weekly Monthly Other

Please detail the patient’s past and present treatment (e.g. date and type of surgery) as well as response to treatment.

Has the patient been hospitalized? Yes No
 If Yes, please provide the name of the hospital(s) and the dates of confinement.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Signature (YYYY/MM/DD)

Name (please print) Specialty

Address (no., street)

Telephone no. Fax no.



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Attending physician’s statement (Psychological conditions)
 In order for Standard Life to properly assess your patient’s claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible.
 Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Surname	Given name(s)	Initial
Date of birth (YYYY/MM/DD)	Height	Weight

Section B – Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I

II

III

IV

V

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? Yes No If Yes, please elaborate.

Please provide a complete list of your patient’s symptoms (*including severity and frequency*), identifying which of the symptoms listed you have objectively observed.

When did symptoms first appear? (YYYY/MM/DD)

Please describe the patient’s initial reason for seeking treatment. Was there a precipitating event? (YYYY/MM/DD)

What was the date of the patient’s first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient’s first visit during the present period of absence from work? (YYYY/MM/DD)

Is your patient’s condition caused directly or indirectly by his/her employment? Yes No If Yes, please elaborate.

What are the patient’s current limitations (*things that he/she cannot do*)? Please be specific.

What are the patient’s current restrictions (*things that he/she should not do*)? Please be specific.

Is your patient competent to manage his/her own financial affairs? Yes No

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

If a potential return to work date has been discussed, please provide the date. (YYYY/MM/DD)

Attending physician's statement (Psychological conditions) *(continued)*

Section C – Treatment

Frequency of patient visits:
 Weekly Bi-weekly Monthly Other

Please detail the patient's past and present treatment (*including psychotherapy*), response to treatment, and compliance.

Has the patient been hospitalized? Yes No
 If Yes, please provide the name of the hospital(s) and the dates of confinement.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

Section D – Functional capacities evaluation

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:
None: No impairment in this area
Mild: Suspected impairment of slight importance which does not affect functional ability.
Moderate: Impairment affects but does not preclude ability to function.
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ability to attend to personal care (<i>bathing, cooking, etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Perform work where contact with others will be minimal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Understand, carry out, and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Make independent judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature (YYYY/MM/DD)

Name (*please print*) Specialty

Address (*no., street*)

Telephone no. Fax no.

**Retirement
Investments
Insurance**

www.standardlife.ca

The Standard Life Assurance Company of Canada

GE10342H-03-2010 GL