

# **A Guide to Claiming Disability Benefits**

**and**

# **Application for Group Weekly Indemnity Insurance**

For everything you ever wanted to know about Group Benefits go to  
[www.cooperators.ca/life/group](http://www.cooperators.ca/life/group)



A Better Place For You™

# ***A Guide to Claiming Disability Benefits***

*(Please keep this section for your reference.)*

***Applying for disability benefits can be confusing. This brochure is designed to assist you in this process and to provide answers to the most commonly asked questions.***

## ***How do I qualify for disability benefits?***

Disability benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury and are paid to you until such time as you can return to work.

To qualify for benefits you must be an eligible covered employee, meet the definition of total disability in your group insurance policy, complete an elimination period, and otherwise satisfy the group insurance policy terms.

Your application for disability benefits does not automatically entitle you to be paid benefits, for reasons that will be stated later in this booklet.

## ***What happens after I submit my claim for disability benefits?***

Your claim will be reviewed as quickly as possible.

We confirm that you are an eligible covered employee by confirming that:

- you are enrolled in the group insurance plan;
- premiums have been paid; and
- you were actively at work before you became disabled.

Once coverage is confirmed we review information submitted to determine whether you are totally disabled as defined in your group policy of insurance. The information that we review includes medical documentation and a description of your job duties.

Your claim will be delayed if insufficient information is provided. In this case we will write to inform you of the delay and we may also ask you to help us obtain more information.

Once your claim is approved, a cheque and letter will be mailed either to you or to your employer. If your claim is denied, we will write to you and explain the reason(s) for the denial.

## ***Will my personal information have privacy protection?***

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business. Co-operators will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding Co-operators' privacy policies, please refer to your Employee Booklet or our website, [www.cooperators.ca/life/group](http://www.cooperators.ca/life/group).

## ***What information does Co-operators Life Insurance Company require to make the claims adjudication decision and what can I do to avoid delays?***

1. Make sure all forms are fully completed.
2. Provide additional details of all factors, both at work and at home, which affect your ability to be at work.
3. Ask your employer to provide your physician and us with your most recent job description and task analysis on each job function.
4. Ask your doctor to include reports from all specialists, results of all testing, and any other medical information. If we do not receive sufficient, clear information, we may be required to write to your physician to obtain the information, resulting in a delay of your claim.
5. Provide copies of CPP/QPP, WCB/WSIB and auto insurance claim records if you have applied for or are receiving any of these benefits.

## ***Why would my claim be denied?***

Your claim will be denied if you are not eligible for the coverage, where we determine that the medical evidence does not support that you are totally disabled, or you do not otherwise qualify for benefits under the group insurance policy.

Research has shown that it is possible and advantageous for people to remain at work while in active treatment for certain medical conditions and that such an approach can actually shorten the recovery period.

Time taken off work due to the pressure and tension that you may experience in your workplace, as the result of such factors as difficult relationships with co-workers, increased workloads and job demands, actions taken by employers in good faith, such as discipline, work evaluation, transfer, lay-off, demotion or termination are generally regarded as a normal part of the work situation and not as a basis for "total disability" (ie. unable to work due to illness or injury).

## ***Why would I be requested to submit additional medical information once my claim has been approved?***

We require periodic updates on your condition and evidence of continuing total disability. In order to obtain this evidence we may send forms for you and your doctor to complete. In some cases, we may write directly to your physician.

The frequency of these requests will depend upon the nature of your condition and the definition of total disability in your group policy.

### ***Rehabilitation and a Safe Return to work.***

If your claim is approved, we may contact you to discuss your return to work. Everyone benefits from your safe and timely return to work. If appropriate, our rehabilitation case manager will work with you, your employer and your physicians to determine and develop the appropriate return to work plan designed just for you.

### ***When should I apply for Canada Pension Plan/Quebec Pension Plan (CPP/QPP) disability benefits?***

Your plan administrator/employer may have already asked you to apply. If not, we will advise you when it is time for you to apply. In most group insurance policies, CPP/QPP benefits must be deducted from disability benefits. If you qualify for CPP/QPP benefits, please send us a copy of your Notice of Entitlement so we can recalculate your benefit amount. If we have overpaid you, you will need to pay us back.

If your claim for CPP/QPP benefits has been denied, we may ask you to appeal that decision or to reapply.

### ***What if I have applied for Workers Compensation (WCB/WSIB) benefits?***

You must still submit your completed insurance claim forms and any other supporting documents to your employer at the same time as you would have, had you not applied to WCB/WSIB. This ensures your claim form is received by us within sufficient time, in the event your Workers Compensation application is denied or benefits are discontinued.

In most policies, WCB/WSIB benefits must be deducted from disability benefits. If you qualify for WCB/WSIB benefits, please notify our office so we can recalculate your benefit amount. If we have overpaid you, you will need to pay us back.

### ***Do I pay premiums while I am receiving WCB/WSIB benefits?***

If you are receiving WCB/WSIB benefits, you may also be able to have your group insurance premiums waived for some or all of your coverages even if you do not receive disability benefits from Co-operators Life Insurance Company.

For information about premium payments when you are receiving WCB/WSIB benefits, please refer to your employee booklet.

### ***How do I claim for Weekly Indemnity (WI) benefits?***

Immediately upon your ceasing work, you, your employer and your doctor must each complete a portion of the Application for Group Weekly Indemnity Insurance. Please ask your doctor to provide as much information as possible in relation to your medical condition such as:

1. test results (blood work, x-rays, CT scans, psychological testing);
2. your doctor's office/chart notes;
3. specialists' consultation reports;
4. hospital admission and discharge summaries, and operative reports; &
5. all other available information relevant to your claim.

If you are age 60 or over, please send a copy of a proof of age (Birth or Baptismal Certificate or Passport).

Payment of WI benefits will cease when:

1. the medical evidence indicates that you are no longer totally disabled;
2. you have recovered sufficiently to allow you to safely return to work. Depending on your group policy, you may be eligible to receive an adjusted (rehabilitation) benefit if initially you need to return to work part-time; or
3. until you have reached the maximum benefit period payable stated in your group insurance policy.

\* Except where prohibited by law, you are responsible for paying any fees your doctor charges for completion of forms or for providing medical reports.

*You can expect to hear from us approximately fifteen days after we receive your claim forms.*

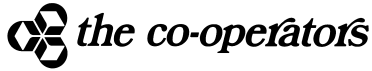
### ***How and when will I receive my WI benefit payments?***

In most cases WI benefits are payable after the elimination period has been completed.

WI benefits are paid every two weeks. The cheques are mailed either to you directly or to your employer, as decided by the policyholder. Our standard practice is to send your cheque to your employer. This insures you are in contact with your workplace and makes your return to work easier for you.

### ***Further questions I may have.***

If you have any questions or if you need help with your WI claim, please contact your plan administrator or our claims office in Regina at 1-800-667-8164. Please have your group policy and personal identification numbers (PID number) ready to give to us to assist with your inquiry.



# CO-OPERATORS LIFE INSURANCE COMPANY

1920 College Avenue, Regina Saskatchewan S4P 1C4

## APPLICATION FOR GROUP WEEKLY INDEMNITY INSURANCE

Employer Statement (Please Print)

Please answer all questions

CLAIMANT INFORMATION			
Claimant's name			
<input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			
Last name		First Name	
Policy / plan no.	Division	S.I.N. No. (for taxable plans only)	
Date of Birth	If age 60 over, copy of birth certificate must be enclosed with claimant's statement	Sex	Telephone No.
Day Month Year		<input type="checkbox"/> Male <input type="checkbox"/> Female	( )
Address			
No. & Street	Suite / Apt. No.	City / Town	Province Postal Code
Occupation State occupation held just before stopping work (please attach job description)	Is condition due to injury or illness arising out of employment? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", has the employee applied for Worker's Compensation Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If "No" please provide details		
Note: If illness/injury is claimed to be work related, the employee must make application to the Worker's Compensation Board for benefits in addition to this plan.			

COVERAGE INFORMATION			
Date of employment	Date employee became <b>insured</b> under:	If employment now terminated, please indicate effective date and/or reason	
Day Month Year	The Co-operators WI policy <input type="checkbox"/> DD <input type="checkbox"/> MM <input type="checkbox"/> YY	Day Month Year	
Date Last Worked	With a previous carrier's WI policy <input type="checkbox"/> DD <input type="checkbox"/> MM <input type="checkbox"/> YY	Average hours worked per week prior to ceasing work	
Day Month Year	Have you discussed a return to work with your employee? <input type="checkbox"/> Yes If "Yes" have you discussed a return to work at: Own Occupation <input type="checkbox"/> Full-Time Date <input type="checkbox"/> Part-Time Date _____	(excluding overtime)	
Date returned to work	or New Job/Duties <input type="checkbox"/> Full-Time Date <input type="checkbox"/> Part-Time Date _____	What days of the week does your employee work? ie. Mon. to Fri.	
Day Month Year	<input type="checkbox"/> No If "No" please explain		
Class/group/union affiliation to which claimant belongs (if applicable)	<input type="checkbox"/> Salaried <input type="checkbox"/> Full-Time <input type="checkbox"/> Hourly <input type="checkbox"/> Part-Time		
	<input type="checkbox"/> Contract (please enclose a copy of the contract agreement)		

EARNINGS / BENEFIT INFORMATION			
State rate of earned gross income immediately before stopping work \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Date rate of earned gross income became effective	
	<input type="checkbox"/> Hourly <input type="checkbox"/> Bi-weekly	Day Month Year	
State claimant's <b>net</b> earned income (after tax deductions, CPP and U.I.C.) immediately before stopping work \$ (Please attach copy of last pay stub)	Is any portion of the premium paid for by the policyholder/ employer? <input type="checkbox"/> No (non taxable) <input type="checkbox"/> Yes (taxable)		
Current tax exception per Federal TD1 \$ (attach TD1)	Other income (sick pay) From To		
	Day Month Year Day Month Year		

Name of employer or organization	Telephone No.	Fax. No.
	( )	( )
Address		
No. & Street	Suite / Apt. No.	City / Town Province Postal Code
Form completed by (other than person claiming)		
Name (Please Print)		Title
Signature		Date
Supervisor's Name _____		
Address: _____ Phone: ( ) _____		

**Employee Statement** (Please Print)

Briefly describe your duties . . . . .  
 . . . . .  
 . . . . .  
 Please provide education level - 1 2 3 4 5 6 7 8 9 10 11 12 Secondary -

Describe your present medical condition, it's cause and history . . . . .  
 . . . . .  
 . . . . .

Date of first treatment for this illness/injury  Day                      Month                      Year	Medical condition has prevented you from working since  Day                      Month                      Year	Have you or did you attempt to return to work? <input type="checkbox"/> No <input type="checkbox"/> Yes Date returned: . . . . .
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Have you ever had a similar injury or illness in the past?  No  Yes If "Yes", describe your condition and the original date of illness or injury.  
 . . . . .  
 . . . . .

List all physicians you have seen for your present medical condition (Attach copies of all available specialists' reports)		Dates of Any Hospitalization		Next Appointment Date
Physician's Name	Address	From	To	

**ACCIDENT INFORMATION - COMPLETE ONLY IF CLAIM IS THE RESULT OF AN ACCIDENT.**

Date of Accident  Day                      Month                      Year	Time of accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Was work being done for an employer at time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Particulars of accident: . . . . .  
 . . . . .  
 . . . . .

If your condition is the result of an injury/accident or motor vehicle accident, please describe the events surrounding the accident:  
 . . . . .  
 a) Was another party at fault?  Yes  No  
 b) Was alcohol involved in the events surrounding the accident?  Yes  No  
 c) Was it reported to police?  Yes  No (if Yes, attach a copy of police report)  
 d) Were any charges laid?  Yes  No If Yes, against whom? . . . . .  
 . . . . .  
 e) Are you pursuing a claim for wage loss against a third party?  Yes  No If No, please give reasons:  
 . . . . .

Are you claiming or receiving any other disability, wage loss, and/or retirement benefits?  No  Yes If "Yes", complete this section .

Type	Amount	Frequency	Effective	Claim No.
<input type="checkbox"/> WCB/WSIB				
<input type="checkbox"/> CPP/QPP				
<input type="checkbox"/> Auto Insurance				
<input type="checkbox"/> EI				
<input type="checkbox"/> Other (e.g. legal action) . . . . .				

**NOTE: ATTACH COPIES OF ALL CORRESPONDENCE YOU HAVE RECEIVED, RELATED TO THE ABOVE MATTER**

**Co-operators Life Insurance Company Privacy Statement**  
 Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

**AUTHORIZATION AND ASSIGNMENT**

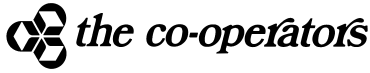
IN CONSIDERATION FOR ANY PAYMENT OF DISABILITY BENEFITS MADE TO ME BY Co-operators, THE POLICYHOLDER OR PLAN ADMINISTRATOR (THE "PAYOR"), I HEREBY AGREE TO REFUND, IN ACCORDANCE WITH THE PROVISIONS OF THE POLICY/PLAN DOCUMENT, FROM ANY SOURCE AS DEFINED UNDER ALL SOURCE BENEFIT AND/OR OTHER INCOME, ANY MONIES THAT MAY BE DUE TO THE PAYOR, AND FURTHER IRREVOCABLY ASSIGN ALL RIGHT, TITLE AND INTEREST OF SUCH MONIES AND ANY GROUP LIFE INSURANCE PROCEEDS TO THE PAYOR FOR SUCH PURPOSE.

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, CLINIC, PHARMACY OR ANY OTHER MEDICAL OR HEALTH CARE PROVIDER OR FACILITY, THE GROUP PLAN ADMINISTRATOR OR THEIR AGENTS, ANY INSURANCE COMPANY, REINSURER, PROVINCIAL HEALTH INSURANCE PLAN, GOVERNMENT DEPARTMENT OR AGENCY, MY EMPLOYER OR FORMER EMPLOYERS, AND ANY OTHER PERSON OR ORGANIZATION HAVING ANY MEDICAL, EMPLOYMENT, VOCATIONAL, FINANCIAL OR OTHER RELEVANT PERSONAL INFORMATION OR RECORDS REGARDING ME TO RELEASE TO AND EXCHANGE WITH Co-operators, THE GROUP PLAN ADMINISTRATOR OR THEIR REPRESENTATIVES AND/OR AGENTS, ANY AND ALL SUCH INFORMATION NECESSARY FOR ANY OR ALL OF THE FOLLOWING PURPOSES: TO INVESTIGATE AND CONFIRM THE ACCURACY AND VALIDITY OF MY CLAIM, DETERMINE MY ELIGIBILITY FOR BENEFITS, ADMINISTER MY CLAIM, ASSESS AND FACILITATE MY ABILITY TO RETURN TO WORK AND ADMINISTER THE GROUP BENEFITS PLAN AND COVERAGE.

I UNDERSTAND THAT MY REFUSAL OR WITHDRAWAL OF CONSENT MAY DELAY CLAIMS ADJUDICATION OR RESULT IN DENIAL OF MY CLAIM. I DECLARE THAT THE INFORMATION PROVIDED IN THIS EMPLOYEE STATEMENT AND ANY STATEMENTS PROVIDED IN ANY PERSONAL OR TELEPHONE INTERVIEW RELATING TO THIS CLAIM ARE/WILL BE TRUE, COMPLETE AND ACCURATE.

THIS AUTHORIZATION SHALL REMAIN VALID FOR THE DURATION OF THE CLAIM UNLESS REVOKED IN WRITING BY ME. ANY COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

\_\_\_\_\_ *Employee Signature* \_\_\_\_\_ *Date* \_\_\_\_\_



CO-OPERATORS LIFE INSURANCE COMPANY

1920 College Avenue, Regina Saskatchewan S4P 1C4

APPLICATION FOR GROUP WEEKLY INDEMNITY INSURANCE

Physician Statement (Please Print)

Please answer all questions

AUTHORIZATION

I authorize the release to the plan administrator and/or plan adjudicator, insurer and my policyholder of any medical information requested for this claim.

Name of Patient (please print)

Signature of Patient (Claimant)

Patient's Date of Birth

Today's Date

Policy/Plan Number

Note: The patient is responsible for obtaining this form and any charges for its completion, except in those provinces governed by statutory regulations that prohibit.

ATTENDING PHYSICIAN'S STATEMENT DIAGNOSIS

Primary Secondary

Other contributing factors/complications

How long have you been treating this patient?

If condition is due to pregnancy, please give expected date of confinement.

Day Month Year

PRESENT CONDITION

Symptoms first appeared or accident happened Date patient ceased work because of present condition Date of first visit for present condition

Has patient ever had same or similar condition? No Yes Unknown If "Yes", state original date of illness/injury and provide details.

SUBJECTIVE AND OBJECTIVE FINDINGS/INVESTIGATIONS

Height Weight Blood Pressure Pulse

Cardiac (if applicable) Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)

Physical Limitations (e.g. range of motion, restrictions on lifting, bending, walking; etc.)

Subjective symptoms (Attach a copy of chart notes from the date of first visit for present condition)

DSM - IV Diagnosis - Axis I: Axis III: Axis V: Axis II: Axis IV: - Current GAF & Date: - Highest GAF in past year:

Table with 3 columns: Investigations (e.g. EKG's, x-ray, lab tests, etc.), Date Carried out, Summary of Results (Attach copies of all available reports.)

Are any further investigations planned? No Yes If "Yes", state type and when

Please attach copies of all chart notes, test results, and consultation reports.

## Physician Statement (continued)

Has your patient been referred to any other physician/specialist?  No  Yes If "Yes", complete the following chart.

Physician's / Specialist Name	Specialty	Dates of Examinations

Summarize physician's findings. ....  
 ....

### TREATMENT

Since first visit, how often have you seen this patient?  Weekly  Bi-weekly  Monthly  Other

Date last treated for condition \_\_\_\_\_ Date of next treatment for condition \_\_\_\_\_

List current medications, dosages, and date commenced. Provide reasons for changes to same.

Dates of hospital admission(s) From <small>Day Month Year</small> To <small>Day Month Year</small>		From <small>Day Month Year</small> To <small>Day Month Year</small>	
Physiotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", frequency <input type="checkbox"/> Daily <input type="checkbox"/> 3x per Week <input type="checkbox"/> Weekly <input type="checkbox"/> Other. ....		Type of physiotherapy <input type="checkbox"/> outpatient/physiotherapy dept. <input type="checkbox"/> independent home exercises	
Surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", type of surgery ..... General or local anesthetic used? .....		Date of surgery <input type="checkbox"/> performed <input type="checkbox"/> planned <small>Day Month Year</small>	
Any other treatment or future plans for treatment? (Specify with dates.) ..... .....			

### LIMITATIONS

Are you aware of what your patient's job duties are? .....

What major tasks of your patient's occupation is he/she able to perform? .....

Unable to perform? (Please list specifics that impair functional activity) .....

What daily living activities are impaired due to this illness and how? .....

What is being done to return your patient to work? .....

Is patient  Ambulatory  House confined  Bed confined

### PROGNOSIS

Progress: Has patient  Recovered  Not Improved  Improved  Retrogressed

1. Have you discussed a return to work date with your patient?

Yes If "Yes", have you discussed a return to work at: Own Occupation  Full-Time Date \_\_\_\_\_ or Other Occupation  Full-Time Date \_\_\_\_\_  
 Part-Time Date \_\_\_\_\_  Part-Time Date \_\_\_\_\_

No If "No", please explain:

Estimated number of weeks before possible return to work

Would vocational counselling and/or retraining be beneficial?  No  Yes If "Yes" please advise date and provide comments

Physician's name (please print)		Fax No. ( )	
Last Name		Telephone No. ( )	
Address		Province	
No. & Street	Suite / Apt. No.	City / Town	Postal Code
Signature of physician		Date	
<input type="checkbox"/> No <input type="checkbox"/> Yes		Family Physician Specialist (Indicate Specialty)	