Group Life & Health

Disability claim form

Initial assessment

COUGHLIN™
employee benefits specialists

STANDARD LIFE

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NOTE : In order to ensure confidentiality of personal information, Standard Life and Coughlin & Associates Ltd. will establish a disability claim file in which information concerning all of your disability claim will be kept. Only employees or authorized agents of Standard Life and Coughlin & Associates Ltd. responsible for the management of your claim, as well as persons to whom you have granted access and to persons authorized by law, 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 and Coughlin & Associates Ltd.
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 Coughlin & Associates Ltd. 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 Coughlin & Associates Ltd. as follows.

   For policies with an elimination period of:

   - 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.
   - 52 weeks, completed forms should be sent to us as of the 46th 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)*

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Disability claims department

Please mail or fax your claim to Coughlin & Associates Ltd. at the following address:

Coughlin & Associates Ltd.
P.O. Box 3517, Station C,
Ottawa, Ontario, K1Y 4H5

Telephone: 1-613-231-2266
Toll Free: 1-888-613-1234
Fax: 1-613-231-2345

www.coughlin.ca

Please maintain all original documents faxed to us.

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 ☐ 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: ☐ 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)*

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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		☐	☐	☐	☐	☐	
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 and Coughlin & Associates Ltd. all medical, financial, or other information deemed relevant by Standard Life and Coughlin & Associates Ltd., permitting the assessment of my claim.

I authorize the Standard Life Assurance Company of Canada and Coughlin & Associates Ltd. to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life and Coughlin & Associates Ltd. 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.

To administer this disability claim as well as expedite its disability rehabilitation and return to work processes, I authorize Coughlin & Associates Ltd. to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions, government agencies, insurance companies, employers or former employers; my local union or plan trustees and auditors; and Coughlin & Associates Ltd. to use the personal information on file to provide me with additional information on any benefits to which I am entitled.

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)*

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Please mail or fax your claim to Coughlin & Associates Ltd. at the following address:

Coughlin & Associates Ltd.
P.O. Box 3517, Station C,
Ottawa, Ontario, K1Y 4H5

Telephone: 1-613-231-2266
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Fax: 1-613-231-2345

www.coughlin.ca

Please maintain all original documents faxed to us.

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? ☐ Yes ☐ No

Nature of request for benefits: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Waiver of premiums ☐ Dismemberment

Was the employee actively at work when the absence began / loss occurred? ☐ Yes ☐ 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? ☐ Part-time *(YYYY/MM/DD)* ☐ Full-time *(YYYY/MM/DD)*

What was the participant's main reason for absence:
☐ Illness ☐ Injury away from work ☐ Motor vehicle accident *(not while working)* ☐ 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: ☐ Salaried ☐ 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? ☐ Yes ☐ No

If Yes, please select one of the following:
☐ Vacation ☐ Maternity leave ☐ Employment insurance ☐ Sick days ☐ Statutory holidays ☐ Other _____

Amount $ _____ From *(YYYY/MM/DD)* to *(YYYY/MM/DD)*

Has the participant submitted a claim to the following government bodies?
☐ WSIB / WCB / CSST ☐ EI ☐ CPP ☐ QPP (RRQ) ☐ Provincial automobile insurance board

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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 ☐ 10 - 20 pounds ☐ 20 - 50 pounds ☐ 50 pounds + ☐ with lifting device? ☐ Yes ☐ No		
7. Pushing/Pulling	0 - 10 pounds ☐ 10 - 20 pounds ☐ 20 - 50 pounds ☐ 50 pounds + ☐		

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

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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 curent 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)*

Disability claim form – initial assessment

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 ☐ N0

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)*

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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	☐	☐	☐	☐	☐
2. Ability to attend to personal care *(bathing, cooking, etc.)*	☐	☐	☐	☐	☐
3. Ability to carry out household chores	☐	☐	☐	☐	☐
4. Ability to relate to co-workers and supervisors	☐	☐	☐	☐	☐
5. Perform work where contact with others will be minimal	☐	☐	☐	☐	☐
6. Understand, carry out, and remember instructions	☐	☐	☐	☐	☐
7. Perform tasks involving minimal intellectual effort or repetitive tasks	☐	☐	☐	☐	☐
8. Perform varied tasks	☐	☐	☐	☐	☐
9. Ability to follow a regular work schedule	☐	☐	☐	☐	☐
10. Make independent judgements	☐	☐	☐	☐	☐
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	☐	☐	☐	☐	☐
12. Supervise or manage others	☐	☐	☐	☐	☐

Signature *(YYYY/MM/DD)*

Name *(please print)* Specialty

Address *(no., street)*

Telephone no. Fax no.