canada life

Waiver of Life Insurance Premiums
Employee Statement

To begin your claim submission:

- Complete the Employee Statement and consent form
- Have your healthcare provider complete a physican's statement
- Submit forms within 8 weeks of the end of waiting period. Your claim may be declined if not submitted within the notice period in your group contract.

NOTE: Canada Life takes the submission of fraudulent claims seriously and will verify the accuracy of the information given in support of your claim.

☐ **I certify the information given on this claim form is true, correct, and complete to the best of my knowledge.**

Your employer's name: _____

Your group plan number: _____ Your Canada Life ID number: _____

Your personal information

First name: _____ Middle initial: _____ Last name: _____

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of birth: _____

Home address: _____

City / Town: _____ Province / Territory: _____ Postal Code: _____

Work location (City / Town and Province / Territory}: _____

Home phone : _____ ☐ Confidential

Cell phone: _____ ☐ Confidential

Email address: _____

Check the confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim.

What level of education have you completed High School ☐ No ☐ Yes Grade Completed _____

Business or Trade School ☐ No ☐ Yes College ☐ No ☐ Yes University ☐ No ☐ Yes Years completed _____

Major/Minor _____ Degree/Diploma/Certificate _____

Your employment information

What was your last day of work (mm/dd/yyyy): _____

What was the first day you were unable to work (mm/dd/yyyy): _____

Have you returned to work? ☐ No ☐ Yes **If yes,** when did you return? (mm/dd/yy): _____

I returned to (select all that apply): ☐ Regular duties and hours ☐ Modified duties ☐ Modified hours

If no, when do you expect to return? (mm/dd/yyyy): _____

OR ☐ Unknown **OR** ☐ I'm not planning to return

What aspects of your job are you able to do?

_____

_____

During your absence, have you performed any **other** work? ☐ No ☐ Yes. If yes, describe:

_____

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Your medical information

What is/was the medical condition causing your absence from work?

_____

Is your condition work related? ☐ No ☐ Yes. If yes, Worker's Compensation case number: _____

Is your condition the result of an accident? ☐ No ☐ Yes **If yes:**

When and where did the accident occur? (mm/dd/yyyy): _____

Provide details of the accident:

_____

_____

Was the accident motor vehicle related? ☐ No ☐ Yes. **If yes,** in what province did your accident occur? _____

Your treatment information

Were you admitted to a hospital? ☐ No ☐ Yes Hospital name: _____

Date admitted (mm/dd/yyyy): _____ Date discharged (mm/dd/yyyy): _____ **OR** ☐ Still hospitalized

Have you had surgery since being off work, or is surgery planned? ☐ No ☐ Yes

Date of surgery (mm/dd/yyyy):_____ Type of surgery: _____

Other treatment (crutches, physiotherapy, medication, etc.):

_____

_____

_____

Please provide the following information for your primary healthcare provider:

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Do you have other healthcare providers related to this claim? ☐ No ☐ Yes **If yes,** provide details.

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Please attach a separate sheet if additional space is required

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Your financial information

Have you applied for, or are you receiving any income either as a result of your disability or otherwise? (check no or yes):

	Applied for	Receiving	Gross Amount	Start Date
• Canada Pension Plan/Quebec Pension Plan:				
o Disability Benefits	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
o Dependent Benefits due to your disability	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
o Retirement Pension	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
o Other (please specify) _____	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
• Worker's Compensation Board (or similar benefits)	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
• Other income (such as Auto Insurance benefits, Employment Insurance, Pension Plan)	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
Please specify _____	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
• Self-employment or other employment income.	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____

Other coverage

Other than the benefits you are applying for here, please indicate if you have other insurance coverage with Canada Life or another insurance carrier:

	Plan/Policy #	Insurance Company
☐ Group Disability Insurance:	_____	_____
☐ Individual Disability Insurance:	_____	_____
☐ Individual Life Insurance	_____	_____
☐ Creditor / Loan Insurance	_____	_____
☐ Critical Illness Insurance	_____	_____

Declaration

☐ I declare the information I've entered is accurate. I understand and agree to the terms in the Income declaration and reimbursement agreement section. I also acknowledge that I need to print, sign, and submit my Consent form to Canada Life.

Your group plan number	Your Canada Life ID number	Date (mm/dd/yyyy)
Your name (please print)	Signature X	

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