

**A Guide to
Claiming Disability Benefits
and
Application for Group
Short Term Disability Benefits**

For everything you ever wanted to know about Group Benefits go to
www.cooperators.ca/groupbenefits



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.

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 to you. 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/en/privacy/privacy.html.

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.

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. Benefits received from CPP/QPP are taxable. Your group disability benefit will be reduced by the before tax CPP/QPP benefit, whether your group disability benefit is taxable or non taxable. 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 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 Short Term Disability (STD) benefits?

Immediately upon your ceasing work, you, your employer and your doctor must each complete a portion of the Application for Group Short Term Disability benefits. 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).

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

How and when will I receive my STD benefit payments?

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

STD benefits are paid every two weeks. Cheques will be mailed to you directly. Electronic funds transfer is available by completing a Direct Deposit Application form (GL 2050) and submitting it to our office. This form is available on our website.

Payment of STD 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 on a part-time basis.
3. until you have reached the maximum benefit period payable stated in your group insurance policy.

Further questions I may have.

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

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

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.	Account No.	S.I.N. No. (for taxable plans only)	
Date of Birth		Sex	Telephone No.
Day Month Year If age 60 over, copy of birth certificate must be enclosed with claimant's statement		<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 insured under:	If employment now terminated, please indicate effective date and/or reason	
Day Month Year	The Co-operators STD policy DD MM YY With a previous carrier's STD policy DD MM YY	Day Month Year	
Date Last Worked	Have you discussed a return to work with your employee?	Average hours worked per week prior to ceasing work	
Day Month Year	<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 ____ or New Job/Duties <input type="checkbox"/> Full-Time Date ____ <input type="checkbox"/> Part-Time Date ____	(excluding overtime)	
Date returned to work	<input type="checkbox"/> No If "No" please explain	What days of the week does your employee work? ie. Mon. to Fri.	
Day Month Year	<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)		
Class/group/union affiliation to which claimant belongs (if applicable)			

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 <input type="checkbox"/> Hourly <input type="checkbox"/> Bi-weekly	Date rate of earned gross income became effective
Day Month Year		Day Month Year	
State claimant's net 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		Other income (sick pay)	
\$ (attach TD1)		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: () _____			

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

Employee Statement (Please Print)

Please answer all questions

CLAIMANT INFORMATION

Claimant's name
 Miss Mr. Mrs. Ms.
Last name First Name

Policy / plan no.	Account No.	S.I.N. No. (for taxable plans only)
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Date of Birth Day Month Year	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No. ()
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If age 60 over, copy of birth certificate must be enclosed with claimant's statement

Address

No. & Street Suite / Apt. No. City / Town Province Postal Code

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, its 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)							
Physician's Name	Address	Dates Seen		Dates of Any Hospitalization		Next Appointment Date	
		From	To	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:

.....

.....

Employee Statement (continued)

Employee Name: _____

Are you claiming or receiving any other disability, wage loss, and/or retirement benefits? <input type="checkbox"/> No <input type="checkbox"/> 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

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

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
Day Month Year	Day Month Year	Day Month Year
Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
<input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 3 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation)			
Physical Limitations (e.g. range of motion, restrictions on lifting, bending, walking; etc.)			
Subjective symptoms _____			
DSM - IV Diagnosis - Axis I: _____ Axis III: _____ Axis V: _____		Cognitive Restrictions: _____	
Axis II: _____ Axis IV: _____ - Current GAF & Date: _____		- Highest GAF in past year: _____	
Attach a copy of chart notes from the date of first visit for present condition			
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", state type and when			

Please attach copies of all chart notes, test results, and consultation reports relating to present condition.

Physician Statement (continued)

Patient's Name: _____

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 _____

Name of Medication	Dosage	Dates Initiated	Reason for Changes in Medication (if applicable)

Dates of hospital admission(s)		From	To				
From	To	Day	Month	Year	Day	Month	Year

Physiotherapy? No Yes If "Yes", frequency Daily
 3x per Week Weekly Other.
 Type of physiotherapy
 outpatient/physiotherapy dept. independent home exercises

Surgery? No Yes If "Yes", type of surgery.
 Date of surgery _____ Day _____ Month _____ Year _____
 General or local anesthetic used?
 performed planned

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