YOUR INDIVIDUAL LIFE WAIVER CLAIM

This document contains the two forms you need to apply for disability benefits under your individual policy and information about the claims process.

- Step 1 - in order to avoid any delays, please complete Part I "Claimant's Initial Statement" in its entirety
- Step 2 - have your treating physician or specialist complete Part II " Attending Physician's Initial Statement"
- Step 3 - once both forms are completed, send your original disability claim form to the Canada Life Head Office at the following address:

  Individual Waiver Claims Department
  PO Box 6000
  Winnipeg MB R3C 3A5

  Note: In furnishing any claim forms, the company does not admit any liability or waive any of its rights. It is your responsibility to have all medical forms completed without cost to Canada Life.
- Step 4 - once we receive your forms we will send you an acknowledgment letter which will provide you with your Claims Specialist's name and contact information.
- Step 5 - your Claims Specialist will then begin the process of reviewing your claim and will notify you of the outcome of our review.

Our Customer Interview Program

As part of our initial review of your claim, you may receive a telephone call from one of our authorized representatives in order to obtain additional information about your claim. The interview normally takes approximately 30 minutes and will be conducted at a time that is convenient for you.

How to get in touch

- Toll free 1.877.280.7541, ext. 8358#
- Fax 204.946.4030
- Email address waiverclaims@canadalife.com

Email Disclaimer

The protection of confidential client information is very important to our organization. Email, although very convenient, is not a secure medium for the exchange of confidential personal information. We cannot guarantee the security of correspondence via email. If you wish to receive correspondence by email, please note that we can take no responsibility for ensuring that the information will remain confidential and not be intercepted or read by others, either over the internet or through the receiving computer. By giving us your email address on page 2, you acknowledge and agree that you are aware of the risk and are accepting this risk.

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PART I:
CLAIMANT'S INITIAL STATEMENT
LIFE WAIVER CLAIM

INDIVIDUAL WAIVER CLAIMS
PO BOX 6000
WINNIPEG MB R3C 3A5
FAX 204.946.4030
1-877-280-7541 ext. 8358#

PART 1 - IDENTIFICATION AND CONTACT INFORMATION

Claimant's name	Home phone number (_____) _____ - _____	Policy number(s)
Date of birth Month _____ Day _____ Year _____	Cellular phone number (_____) _____ - _____	
Home address City Province Postal Code		Email address (optional) **(Please see Email Disclaimer on page 1)**

PART 2 - CLAIM DETAILS

1. Claiming benefits from: Month _____ Day _____ Year _____ to Month _____ Day _____ Year _____

2. Are you currently working in any capacity? ☐ Yes ☐ No
   a) If NO, when was your last day of work? Month _____ Day _____ Year _____
   b) If YES, on what date did you return to work? Month _____ Day _____ Year _____
   If you are working reduced hours or performing modified duties, please provide details:

3. What is your disabling condition and/or diagnosis?

4. Please describe the nature of your signs, symptoms and limitations and how they impact your ability to work.

5. When did the signs or symptoms for your condition first appear? Month _____ Day _____ Year _____

6. Have you had the same/similar signs or symptoms in the past? ☐ Yes ☐ No
   If YES, when? Month _____ Year _____

7. If your condition is a result of an accident:
   a) Date of Accident: Month _____ Day _____ Year _____
   b) Was the accident work related? ☐ Yes ☐ No
   c) Please provide a description of the accident.

   d) Please describe the injuries sustained.

8. If your disability is due to pregnancy complications, when is your due date? Month _____ Day _____ Year _____

9. For a disability involving the upper extremities are you: ☐ Right handed ☐ Left handed

10. Please provide your: Height _____ Weight _____ ☐ lbs ☐ kgs

PART 3 - EMPLOYMENT INFORMATION

1. Occupational information: ☐ Self employed ☐ Employee ☐ Retired: Month _____ Day _____ Year _____
(If retired, please proceed to Part 4 - Treatment)

2. Employer's/Business name Phone number (_____) _____ - _____ Website:

Address City Province Postal Code

3. a) Job title _____ b) Nature of business _____
c) How long have you been working at your current occupation? _____
d) How many hours per week did you normally work prior to disability? _____
e) Monthly income prior to disability: Gross _____ Net _____

4. Occupational duties:
a) What percentage of your time was spent on the following? (Please note that the total must add up to 100%.)
Administrative/Office: _____ Manual/Physical: _____ Sales: _____
Supervisory: _____ Other (Please describe): _____
b) Please provide a detailed description of your occupational duties prior to onset of disability.

5. Please describe the occupational duties you are currently able to perform.

⚠ IF SELF EMPLOYED, PLEASE PROVIDE THE ADDITIONAL DETAILS:

6. a) Is your business: ☐ incorporated ☐ unincorporated b) Your percentage of ownership: _____ % c) Number of full-time employees _____ Number of part-time employees _____ Number of business partners _____

d) Is your business still operating? ☐ Yes ☐ No If YES, name of person operating it? _____
e) Have you hired someone to replace you? ☐ Yes ☐ No Name: _____

⚠ IF UNEMPLOYED, PLEASE PROVIDE THE ADDITIONAL DETAILS:

7. Date of last employment? Month _____ Day _____ Year _____

PART 4 - TREATMENT

1. Caregivers **(PLEASE INCLUDE ALL DOCTORS, PHYSIOTHERAPISTS, CHIROPRACTORS, PSYCHOLOGISTS, PSYCHIATRISTS, ETC.)**

i) Name Phone number (_____) ____ - _____	Date of first consultation: Month _____ Day _____ Year _____
Specialty Fax number (_____) ____ - _____	Date of last consultation: Month _____ Day _____ Year _____
Address	Date of next consultation: Month _____ Day _____ Year _____
City Province Postal Code	Frequency of visits (weekly, monthly, other) _____
ii) Name Phone number (_____) ____ - _____	Date of first consultation: Month _____ Day _____ Year _____
Specialty Fax number (_____) ____ - _____	Date of last consultation: Month _____ Day _____ Year _____
Address	Date of next consultation: Month _____ Day _____ Year _____
City Province Postal Code	Frequency of visits (weekly, monthly, other) _____
iii) Name Phone number (_____) ____ - _____	Date of first consultation: Month _____ Day _____ Year _____
Specialty Fax number (_____) ____ - _____	Date of last consultation: Month _____ Day _____ Year _____
Address	Date of next consultation: Month _____ Day _____ Year _____
City Province Postal Code	Frequency of visits (weekly, monthly, other) _____

PART 4 - TREATMENT (CONTINUED)

2. Were you hospitalized? ☐ Yes ☐ No **If YES, please provide us with the following details.**

Hospital Name Phone Number (_____) _____ - _____ Admission date: Month _____ Day _____ Year _____

Address Discharge date: Month _____ Day _____Year _____

City Province Postal Code

3. Are you currently taking any medications? ☐ Yes ☐ No **If YES, please provide us with the following details.**

i) Medication: Dosage: **iii)** Medication: Dosage:

ii) Medication: Dosage: **iv)** Medication: Dosage:

4. Are you receiving any other forms of treatment? ☐ Yes ☐ No **If YES, please describe.**

5. Please provide details of any future treatment, upcoming consultations and/or tests.

6. a) Has a return to work been discussed with your doctor? ☐ Yes ☐ No **Please provide details.**

b) Expected return to work date? Month _____ Day _____ Year _____ ☐ Full-time ☐ Part-time ☐ Unknown

PART 5 - OTHER INSURANCE

Are you eligible to receive any disability benefits from the following list (whether or not your claim has been submitted and/or approved)?

	Yes	No	Policy / Claim No.	Issue Date of Policy	Monthly Benefit Amt.	Benefit Start Date	Benefit Period	Submitted, Approved or Declined	Examiner's Name & Phone No.
Business Overhead Expense Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
WCB / WSIB	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Automobile Insurance Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Employment Insurance Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Group Insurance Plan Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Creditor Insurance (Loan and mortgage) Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Canada Pension Plan/ RRQ	☐	☐		mm/dd/yyyy		mm/dd/yyyy			
Other Individual Policy Name:	☐	☐		mm/dd/yyyy		mm/dd/yyyy			

PART 6 - PROTECTING YOUR PERSONAL INFORMATION

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life, or the offices of an organization authorized by Canada Life. This information about you may include medical and psychiatric information. Canada Life may use service providers located within or outside of Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life, who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, store, use and disclose the personal information to investigate and assess your claim(s) with Canada Life. For a copy of our Privacy Guidelines, or if you have any questions about our personal information policies and practices (including with respect to service providers), write to Canada Life Chief Compliance Officer or refer to www.canadalife.com.

PART 7 - AUTHORIZATION AND DECLARATION

I have read and understand and agree with the contents of the section entitled “Protecting Your Personal Information” on this form.

I authorize:

- Canada Life, any health care or rehabilitation provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Canada Life, or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s). This may include performing independent assessments.

I acknowledge that the personal information is needed to investigate and assess my claim(s). I acknowledge that my consent enables Canada Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written notice.

This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

_____

Print Claimant Name

_____

Claimant Signature

_____

Date

PLEASE BE ADVISED THAT YOUR CLAIM WILL BE REVIEWED WHEN THE CLAIMANT’S INITIAL STATEMENT AS WELL AS THE PHYSICIAN’S INITIAL STATEMENT ARE RECEIVED.
PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR ANY FEES INCURRED FOR COMPLETING THE PHYSICIAN’S INITIAL STATEMENT.

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PART II:
ATTENDING PHYSICIAN'S INITIAL STATEMENT
LIFE WAIVER CLAIM

INDIVIDUAL WAIVER CLAIMS
PO BOX 6000
WINNIPEG MB R3C 3A5
FAX 204.946.8874

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S DISABILITY CLAIM, PLEASE ANSWER ALL OF THE QUESTIONS IN FULL.

PATIENT INFORMATION

Name (please print)	Policy number	Date of birth Month _____ Day _____ Year _____
Address		Telephone number (including area code)

PLEASE COMPLETE SECTIONS A AND/OR B AS APPLICABLE AND THEN PROCEED TO SECTION C (PLEASE PRINT)

SECTION A - PHYSICAL DIAGNOSIS

Primary diagnosis:

Secondary and/or complications:

Objective medical findings (including results of all diagnostic tests):

Physical Impairment:

- ☐ Class 1 (no limitation - capable of strenuous physical activity)
- ☐ Class 2 (slight limitation - capable of moderate activity)
- ☐ Class 3 (moderate limitation - capable of light activity)
- ☐ Class 4 (marked limitation - capable of minimal activity)
- ☐ Class 5 (severe limitation - incapable of minimal activity)

Are any tests/investigations pending? ☐ Yes ☐ No
If YES, specify its nature and provide the expected date of completion. Month _____ Day _____ Year _____

SECTION B - PSYCHIATRIC DIAGNOSIS (DSM-IV OR DSM-5)

Primary diagnosis (please include diagnostic code):

Secondary and/or other contributing disorders:

Severity of psychosocial stressors
(please circle one option)
0 1 2 3 4 5

0 - non-existent
1 - mild
3 - moderate
5 - severe

Factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

- ☐ Workplace Issues
- ☐ Physical/Medical Condition
- ☐ Coping Skills
- ☐ Personality/Motivation
- ☐ Social/Family Issues
- ☐ Financial/Legal Problems
- ☐ Alcohol/Drug Abuse
- ☐ Other Issues _____

Severity of functional impairment. Please describe.

- ☐ Mild
- ☐ Moderate
- ☐ Severe

SECTION C - SYMPTOMS

1. When did the reported symptoms first appear? Month _____ Day _____ Year _____

2. Please list the current symptoms and their degree of reported severity:

Symptoms	Mild	Moderate	Severe
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

3. Specifically, how do the reported symptoms affect his/her ability to work?

SECTION D - TIMELINE

1. Date the patient's condition first prevented them from working? Month _____ Day _____ Year _____

2. Did you recommend that the patient stop work? ☐ Yes ☐ No

3. Has the patient ever had the same or similar condition? ☐ Yes ☐ No Month _____ Year _____
   If YES, please provide details:

4. Are there any previous medical conditions contributing to the patient's current impairments?

5. When did you start treating the patient for this condition? Month _____ Day _____ Year _____
   a) Date of last visit: Month _____ Day _____ Year _____
   b) Date of next visit: Month _____ Day _____ Year _____
   c) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

6. Date of Hospitalization ☐ N/A Name of Hospital _____
   Admission: Month _____ Day _____ Year _____
   Discharge: Month _____ Day _____ Year _____

SECTION E - TREATMENT

1. What is the nature of current treatment (including type and frequency, surgery performed or contemplated)?

2. Medications:

Name and Dosage	Date Started	Last Dosage Change Date	Frequency	Response

3. Is the patient following the recommended treatment program? ☐ Yes ☐ No **Please elaborate:**

4. Has the patient's clinical status: ☐ Improved? ☐ Remained Stable? ☐ Deteriorated?
   Please explain.

5. Has a specialist referral been made? ☐ Yes ☐ No
   If YES, please complete the following information:

Doctor's Name	**Specialty**	**Date of Referral or First Visit**

6. Are there any other changes in the patient's treatment plan being considered or underway? ☐ Yes ☐ No
   Please explain.

SECTION F - RETURN TO WORK

1. Has a return to work plan been established? ☐ Yes ☐ No

   a) If NO, when will the patient be assessed for a possible return to work? Month _____ Day _____ Year _____

   b) If YES, what is the expected return to work date? Month _____ Day _____ Year _____

   ☐ Full time ☐ Part time ☐ Gradual

   c) If a return to work is part time or gradual, what is the recommended work schedule?

SECTION G - REMARKS

Additional comments to report on the evaluation of the patient.

IN ORDER TO EXPEDITE THE CLAIMS PROCESS, PLEASE PROVIDE COPIES OF ALL RELEVANT CHART NOTES, CONSULTATION REPORTS AND TEST RESULTS.

SECTION H - SIGNATURE (please print or use a stamp)

Last Name	First Name	Specialty
Address		Telephone Number
City	Province	Fax number
Postal Code	Signature	Date Month _____ Day _____ Year _____

PLEASE BE ADVISED THAT YOUR PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES INCURRED FOR ITS COMPLETION.