



Wawanesa
Life

Group Disability Notice of Claim

Short Term Disability
Long Term Disability
Life Waiver of Premium

Group Disability Notice of Claim

What you should know

1. Notice of Claim

The notice of claim asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Your employer must complete the “Employer’s Statement”, your treating physician must complete the “Physician’s Statement” and you must complete the “Employee’s Statement”.

2. Submission of Claim

The Notice of Claim forms must be submitted and received by Wawanesa Life at its Head Office within:

- 30 days from the end of the Qualifying Period for Short Term Disability,
- 60 days from the end of the Qualifying Period for Long Term Disability,
- 180 days from the date of disability for Life Waiver of Premium.

3. Authorization

Your permission is required to obtain information that will help assess your claim. By signing this authorization request, you give Wawanesa Life permission to obtain this information from your medical practitioners, your employer, other insurers and medical facilities where you received treatment.

4. Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Wawanesa Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.



Group Division
400 – 200 Main Street, Winnipeg, MB R3C 1A8
1-800-665-7076

Disability Notice of Claim Form Employer's Statement

PART 1: EMPLOYER INFORMATION

Employer Name	Area Code, Telephone and Fax No.	Policy #
_____	_____	_____
Employer Address		
Street & Number	City	Province Postal Code
_____	_____	_____

PART 2: EMPLOYEE INFORMATION

Employee Name (Last, First)	Date of Full-Time Employment (yy/mm/dd)	Effective Date of Employee's Insurance (yy/mm/dd)
Is the Employee's Group Insurance In Force? Yes <input type="checkbox"/> No <input type="checkbox"/>	If cancelled, give date (yy/mm/dd) and the reason why:	
Date Last Worked (yy/mm/dd)	On that day, did employee work a full day? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, how many hours worked? _____	Why did employee stop working?
If laid off or on leave, date of commencement of layoff or leave (yy/mm/dd) and scheduled date of recall:	Is Employee's condition work related? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, has a claim been filed with WCB? Yes <input type="checkbox"/> No <input type="checkbox"/>
If applicable, return to work date (yy/mm/dd)		
If yes, send initial report of illness or injury and award notice.		

PART 3: EMPLOYEE SALARY INFORMATION

If hourly paid, what is hourly rate?	If salaried, what is yearly salary?	Effective Date of current rate of pay/salary (yy/mm/dd)
What was the employee's scheduled work week?	_____ hours per week	Date to which salary or sick leave benefits were paid (yy/mm/dd)
Will employee file for disability benefits provided by any employer/employee labour management, union welfare plan or group pension plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, what is weekly amount?	When do benefits begin? (yy/mm/dd)	When do benefits end? (yy/mm/dd)
Has the employee received or is the employee entitled to receive other disability payments since the last time at work?		
(A) Wages, salary continuance or other disability insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(B) Any employee pension plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(C) Any government agency plan, worker's compensation or similar benefits	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, give particulars in the appropriate column:	Particulars	(A) (B) (C)
	Date of Commencement	
	Amount of Payment	
	Frequency of Payment	

PART 4: EMPLOYEE JOB DESCRIPTION

A) What is the employee's occupation? _____	How long has employee been in this position? _____
What department does the employee work in? _____	
B) What are the main duties of the employee's job and percentage of time allocated?	C) Lifting must be performed?
Duties _____ % _____	Occasionally _____
Duties _____ % _____	Frequently _____
Duties _____ % _____	Continuously _____
D) Mobility – Does the job involve:	E) Equipment: Please list any office machines, tools or other equipment that the employee uses in his/her job
N/A 1-25% 25-50% 50-75% 75-100%	Type % of Day
Walking _____	_____
Climbing _____	_____
Sitting _____	_____
Reaching _____	_____
Above shoulder height? _____	_____
At shoulder height? _____	_____
Below shoulder height? _____	_____
Bending or Crouching? _____	_____
Kneeling or crawling? _____	_____
F) Strength – Does the job require the employee to lift or carry more than:	
N/A 1-25% 25-50% 50-75% 75-100%	
50 lbs/22.7 kg? _____	
20 lbs/9.1 kg? _____	
10 lbs/4.5 kg? _____	



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Disability Notice of Claim Form Employee's Statement

PART 1: EMPLOYEE INFORMATION

Employer Name				Policy #	
Employee Name (Last, First)	Male <input type="checkbox"/>	Date of Birth (yy/mm/dd)	Height	Weight	
Female <input type="checkbox"/>					
Employee Address					
Street & Number		City or Town		Province	Postal Code
Social Insurance Number	Area Code and Telephone number where you can be reached for a telephone interview:			Occupation	

PART 2: FAMILY INFORMATION (For Waiver of Premium)

Spouse's Name (Last, First)	Date of Birth (yy/mm/dd)	Is your spouse employed?	
Children under age 25: Name (Last, First)	Date of Birth (yy/mm/dd)	Married?	Attending School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PART 3: DISABILITY INFORMATION

If illness, please answer the following questions

Please describe the nature of your illness

What were your first symptoms?	When did you first notice symptoms	Date Treated (yy/mm/dd)
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If accident, please answer the following questions

Where and how did the injury occur

Time & Date (yy/mm/dd) injury occurred	Were you hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Admission Date (yy/mm/dd)	Discharge Date (yy/mm/dd)
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For illness or accident, please answer the following questions

Why are you unable to work?

Is your condition related to your occupation? If yes, please explain.

Are you in receipt of or do you intend to claim for:	Worker's Compensation Board _____	Employment Insurance _____	
	Automobile Insurance _____	Other Earnings _____	

Indicate weekly amount, start and end date of benefit: _____

List all doctors you have consulted because of your present disability or any other reason during the past two years:

Name	Address	Date First Consulted	Date Last Consulted	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PART 4: EMPLOYMENT INFORMATION

Last day you worked before disability (yy/mm/dd)	Was it a full day? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date you were first unable to work (yy/mm/dd)	Have you returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when? _____ Part-time _____ Full-time _____
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If you have not returned to work, when do you expect to?	Any additional information you would like to provide?
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PART 5: AUTHORIZATIONS AND DECLARATIONS

PROTECTING YOUR RIGHT TO PRIVACY

At Wawanesa Life, we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Wawanesa Life. We limit access to information in your files to Wawanesa Life staff or persons authorized by Wawanesa Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to investigate and assess your claim and to administer the group benefit plan. You can obtain further information about Wawanesa Life's personal information protection policy from the Wawanesa Life Head Office at 400 – 200 Main Street, Winnipeg, MB R3C 1A8 or www.wawanesalife.com

I authorize:

- **Wawanesa Life, any healthcare provider, my plan administrator, other insurance companies, administrators or government benefits, other organizations, or benefit service providers working with Wawanesa Life to exchange personal information, when necessary to investigate and assess my claim and to administer the group plan benefit.**
- **Wawanesa Life to exchange personal information with my employer, plan sponsor, or plan administrator for the purpose of discussing rehabilitation.**
- **Wawanesa Life to collect, use and disclose my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.**

This authorization shall remain valid for the duration of my claim 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 any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of this claim.

Print Name

Signature

Date

Telephone Number

For Head Office Use Only



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**Disability
 Notice of Claim Form
 Attending Physician's Statement**

This is not a request for examination, but for information from your chart.

Policy #: _____

The patient is responsible for securing this form and for any charges for its completion.

Name of Patient _____

Date of Birth: _____

I hereby authorize the release of any information requested on this form to Wawanesa Life

Signature _____

Date: _____

1. History

Date of symptom onset (yy/mm/dd) _____

Has the patient ever had the same or similar condition? Yes No

If yes, please specify diagnosis and dates of treatment: _____

2. Diagnosis (including any complications)

Primary: _____ ICD-9-CM Code: _____

Secondary: _____

Subjective Symptoms: _____

Objective Signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

3. Current Height: _____ Current Weight: _____

4. In your opinion, when did the patient's condition first prevent him/her from working? _____

5. If condition is due to pregnancy, what is the dated/expected date of confinement? _____

6. If condition is due to mental disorder, indicate current Global Assessment of Functioning score (G.A.F.) according to the Diagnostic and Statistical Manual Fourth Edition (D.S.M. IV)
 Is patient cable of handling his/her own financial affairs? _____

7. Is the Condition due to injury or sickness arising out of the patient's employment? Yes No

If yes, has your office filed a claim for this condition with the Worker's Compensation Board on behalf of your patient? Yes No

8. Treatment

What is the current treatment regimen? (drug dosage, physiotherapy, other and progress)

Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

9. Hospitalization if applicable for this illness or injury:

Date of in-patient admission: _____
Date of discharge: _____
Date of out-patient treatment: _____
Name of Hospital: _____

10. Surgery

Surgical procedure performed: _____
Date of surgery: _____
Name of surgeon: _____

11. Please provide the names and specialty of other physicians who have been/will be involved in assessing the medical problems.

12. Please indicate your patient's current physical abilities:

- Sedentary Duties Requires mainly sitting, occasional walking and standing and possible lifting of 5 kg or less.
- Light Duties Requires frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.
- Medium Duties Requires frequent handling of loads of up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing or pulling may also be required.
- Heavy Duties Requires frequent handling of loads of up to 23 kg, sometimes up to 45 kg.

List physical restrictions and tolerances: _____

In your opinion, what is the earliest date your patient will be able to return to work? _____

If the previous job could be modified, when could rehabilitation employment begin? _____

11. We would appreciate any additional comments that would help us to better understand your patient and his/her condition.

Name of Physician (please print): _____ Specialty: _____
 Telephone #: _____ Fax #: _____
 Address: _____
 Physician's Signature: _____ Date: _____

For Head Office Use Only
