



***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

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

### PART 2: EMPLOYEE INFORMATION

<b>Employee Name</b> (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? _____	If applicable, return to work date (yy/mm/dd)
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 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**

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

**PART 2: FAMILY INFORMATION (For Waiver of Premium)**

<b>Spouse's Name (Last, First)</b>		<b>Date of Birth (yy/mm/dd)</b>	<b>Is your spouse employed?</b>
Children under age 25: Name (Last, First)		Date of Birth (yy/mm/dd)	Married? <input type="checkbox"/>
_____		_____	_____
_____		_____	_____
_____		_____	_____

**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)
_____	_____	_____

**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)
_____	_____	_____	_____

**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](http://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

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