400-200 Main Street
Winnipeg, MB R3C 1A8
Toll free: 1-800-665-7076
grpdisability@wawanesa.com

Short Term Disability Claim Checklist and Direct Deposit Authorization

Print Save Clear Form

Claim Checklist

To ensure the assessment of your Group Short Term Disability benefit is completed as quickly as possible, please review the following items and verify they have all been included.

- ☐ Plan Member Statement – signed and completed by you
- ☐ Plan Sponsor Statement – signed and completed by your Plan Sponsor
- ☐ Attending Physician Statement – signed and completed by your physician
- ☐ Authorizations and Declarations Form – signed by you
- ☐ Direct Depostit Authorization signed and completed by you, include a copy of a void cheque

Direct Deposit Authorization

Direct deposit is the method of payment by Wawanesa Life. If you have not already signed up, please complete this section.

☐ Initial Request ☐ Modification	Group Plan #	Plan Member ID
Plan Member Surname	First Name	Telephone Number

Financial institution name	Financial institution address

Type of bank account:	Branch number	Institution number	Account number
☐ Chequing ☐ Savings			

Please attach a personalized voided cheque with this form.

I hereby authorize The Wawanesa Life Insurance Company ("Wawanesa Life") to deposit my benefit payment to the account and the financial institution specified above. This authority is to remain in full force and effect until Wawanesa Life has received written notification from me of its termination in such time and in such manner as to afford a reasonable opportunity to act on it.

Should Wawanesa Life inadvertently deposit into my account any monies not rightfully belonging to me, I authorize Wawanesa Life to debit my account for such amount.

Signature	Date (yy/mm/dd)	Account holder signature (if applicable)	Date (yy/mm/dd)

For Wawanesa Life use only	Received

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Group Short Term Disability Benefit
Plan Member Statement

Plan Member Information

Plan Sponsor			Group Plan #
Plan Member(Last Name, First Name, Initial)		☐ Male ☐ Female	Date of Birth (yy/mm/dd)
Address	City	Province	Postal Code
Phone Number		Email	

I authorize the use of my Social Insurance Number for income tax reporting purposes when required in administering my Short Term Disability benefit.

Social Insurance Number	**Signature**

Family Information

Spouse's name (Last Name, First Name)	Date of Birth (yy/mm/dd)	Is your spouse employed? ☐ Yes ☐ No	
Dependent Children: (Last Name, First Name)	Date of Birth (yy/mm/dd)	At Home	In School

Disability Information

Please describe your current condition and how it prevents you from working.

What were your first symptoms?	When did you first notice symptoms?

If accident, describe the injury, how it occured and how it prevents you from working.

Where did the accident/injury occur?

Time & date of accident (yy/mm/dd)

Please provide a copy of the incident / police report

Was another party at fault? ☐ Yes ☐ No Was alcohol involved? ☐ Yes ☐ No

Was it reported to the police? ☐ Yes ☐ No Were any charges laid? ☐ Yes ☐ No

Are there any other factors that prevent you from working?

Disability Information

Is your condition related to your occupation? Please explain:

Has a claim been filed with another wage loss provider? ☐ Yes ☐ No If 'Yes' select provider

☐ WCB/WSIB/CSST ☐ CPP/QPP ☐ Auto ☐ Other, specify

Date Filed (yy/mm/dd)	Decision	Amount

Treatment Information

Date first treated (yy/mm/dd)

Were you hospitalized? ☐ Yes ☐ No If 'Yes', where

Admission Date (yy/mm/dd) Discharge Date (yy/mm/dd)

List all health care providers you have consulted during the past two years (eg. chiropractor, doctor)

Name	First Consultation	Last Consultation	Reason

Since your absence from work, what type of treatment have you received? *(eg. Medical, physiotherapy, counselling, etc.)*

Current Employment Information

Enter all dates in yy/mm/dd format

Last day you worked before disability	Hours Worked	Date you were first unable to work	Have you returned to work? If 'Yes' when	
			☐ Full time	☐ Part Time

If you have not returned to work, when do you expect to?

Have you performed any other work since that date? If 'Yes' describe.

Are you able to do any other work? If 'Yes' describe.

Financial

Please provide copies of any initial benefit statements

Have you applied for or are receiving the following:

	Applied Yes	Applied No	Awarded Yes	Awarded No	Amount
Canada Pension Plan / Quebec Pension Plan	☐	☐	☐	☐	
Workers' Compensation Board Benefits (or similar)	☐	☐	☐	☐	
Employment Insurance Benefits	☐	☐	☐	☐	
Automobile Insurance Benefits	☐	☐	☐	☐	
Any other Disability Benefits	☐	☐	☐	☐	
Employer Sponsored Retirement / Pension Plan Income	☐	☐	☐	☐	
Self Employment Income or other Employment Income	☐	☐	☐	☐	
Old Age Security	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

For the duration of your claim for benefits, it is your responsibility to notify Wawanesa Life of:

- *any work performed, whether or not you have received a wage or remuneration*
- *any employment income paid to you or any other person or party as a result of work performed by you*

Authorizations and Declarations

Authorizations

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my Disability Claim.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my claim under this policy, with the insurer's reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the policy.

Consent & Disclosure Regarding Personal Information

I consent to Wawanesa Life collecting, using and disclosing 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.

I understand that Wawanesa Life may share my personal information with the following people, organizations and service providers: Wawanesa Life employees who require this information to perform their jobs; claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions. I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 400-200 Main Street, Winnipeg, MB R3C 1A8.

If you have a question (including a question concerning our collection of personal information or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance:

Vice President, General Counsel and Secretary
The Wawanesa Life Insurance Company
900-191 Broadway
Winnipeg, Manitoba R3C 3P1

Declaration and Signature

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended me and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting me for the purpose of administering my Disability Claim.

A photocopy or an electronic reproduction of this document will be as valid as the original.

Group Plan #	**Plan Member Name (Print)**
Date (yy/mm/dd)	**Plan Member Signature**