



**APPLICATION FOR LONG TERM DISABILITY BENEFITS**  
**Employee Statement**  
 PLEASE PRINT

**PLEASE COMPLETE AND SIGN THIS PORTION OF YOUR APPLICATION FOR LONG TERM DISABILITY BENEFITS. RETURN THIS FORM PROMPTLY TO YOUR EMPLOYER. NOTE: YOUR SIGNATURE IS ALSO REQUIRED ON THE ATTENDING PHYSICIAN'S STATEMENT.**

**IMPORTANT: Failure to fully answer all questions will delay the processing of your claim.**

Policy/Plan No.	Account No.	S.I.N. <input type="text"/>	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Waiver Group Life Insurance Premium (if applicable)
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.				
last name			first name	
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	If age 60 or over, endorse copy of birth certificate.	Height	Weight
Day	Month	Year		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Telephone number <input type="text"/>		
Address				
No. & Street		Suite/Apt. No.	City/Town	Province    Postal Code
Your Plan Sponsor/ Employer			Occupation	Employer's Telephone Number <input type="text"/>
Address				
No. & Street		Suite/Apt. No.	City/Town	Province    Postal Code
Describe your present medical condition, its cause and history. If you were injured, also describe accident, including date, time and where it took place.				
Date symptoms began		Date of first treatment for this illness/injury		Medical condition has prevented me from working since
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	Month	Year	Day	Month
Have you ever had a similar injury or illness in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe your condition, the original date of illness or injury, and any time lost from work.				
If your condition is the result of an injury or motor vehicle accident, please describe the events surrounding the accident:				
a) Was another party at fault? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Was alcohol involved in the events surrounding the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c) Was it reported to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach a copy of police report.) d) Were any charges laid? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, against whom?) e) Are you pursuing a claim for wage loss against a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please give reasons)				

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	

Has your doctor told you to restrict your activities in any way?  Yes  No If "Yes", state what he/she told you about restricting your activities.

Have you discussed a return to work with your employer?  Yes If "Yes", have you discussed a return to work at:  
 Own Occupation  Full-time Date / /   Part-time Date / /  **OR**  
 New Job/Duties  Full-time Date / /   Part-time Date / /

Have you discussed a return to work with your physician?  Yes If "Yes", have you discussed a return to work at:  
 Own Occupation  Full-time Date / /   Part-time Date / /  **OR**  
 New Job/Duties  Full-time Date / /   Part-time Date / /

No If "No", please explain:

**OTHER INCOME**

Have you applied for or are you receiving any other disability, wage loss, and/or retirement benefits?  Yes  No If "Yes", complete this section.

WCB                      Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Effective \_\_\_\_\_ Claim No. \_\_\_\_\_

CPP/QPP                      Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Effective \_\_\_\_\_ Claim No. \_\_\_\_\_

Car Insurance                      Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Effective \_\_\_\_\_ Claim No. \_\_\_\_\_

EIC                              Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Effective \_\_\_\_\_ Claim No. \_\_\_\_\_

Other (e.g. legal action, retirement pension, creditor insurance, mortgage insurance, etc.) \_\_\_\_\_

**NOTE: ATTACH COPIES OF ALL CORRESPONDENCE YOU HAVE RECEIVED, RELATED TO THE ABOVE MATTER.**

**PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS - COMPLETE REVERSE SIDE OF THIS FORM.**

## Summary of Claimant's Education, Training and Experience (PLEASE PRINT)

Note: This information is important to the assessment and administration of your claim. **Please complete in full. (Attach a separate sheet if necessary.)**

### EDUCATION/TRAINING

Indicate the highest grade level of education completed:

Grade 6 or under   
  7   
  8   
  9   
  10   
  11   
  12   
  13

Name of technical or trade school attended:

Type of diploma obtained:

Name of college or university:

Number of years completed:

Type of degree obtained:

Other training, special or vocational courses:


### WORK EXPERIENCE

**Present Employment:** Briefly describe your duties and when you started in this job:


**Previous Employment:** Please complete the following, providing details of your **previous** positions.

Employer	Job Title and Duties	Duration of Employment	
		From	To

**Job Skills:** What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc.) Where appropriate, give level of proficiency.


**Community Interests:** Outline your past or present involvement with any community/church/volunteer organizations

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**Hobbies:**

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### AUTHORIZATION AND ASSIGNMENT

I hereby agree to refund any monies which may be due to the insurance company, policyholder or plan administrator as a result of payment of disability benefits from any source listed in Other Income, in accordance with the provisions of the policy/plan document and further assign such monies to the insurance company.

I have read the foregoing, and the above answers are true and complete to the best of my knowledge and belief. I authorize any hospital, physician, medical health care professional, or other medical or medically related institution, insurance company, employer, government agency, or other organization, institution or person, to release to Co-operators Life Insurance Company, the Plan Adjudicator, or the Plan Administrator, any and all information with respect to any illness, injury, medical history, consultation, prescriptions, treatment and to provide copies of any other records relating to the insured's health. A facsimile transmission or photocopy of this authorization shall be considered as valid as the original.

EMPLOYEE'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



ATTENDING PHYSICIAN'S INITIAL DISABILITY BENEFITS STATEMENT

PATIENT'S AUTHORIZATION TO RELEASE INFORMATION

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Policy/Plan No. \_\_\_\_\_

I hereby authorize the release to the Plan Administrator and/or Plan Adjudicator and my Insurer of any information requested in respect of this claim. Note: The patient is responsible for obtaining this form and for any charges for its completion except in those provinces where prohibited by statutory regulations.

Date \_\_\_\_\_ Signature of patient \_\_\_\_\_

ATTENDING PHYSICIAN'S STATEMENT

TO PHYSICIANS - PLEASE NOTE:

This form has been specifically designed with the Physician in mind. By being comprehensive, it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and stroke out non-applicable areas. In order to help the claimant, sufficient details of History, Investigation, Findings and Treatment are essential. Your patient is responsible for the cost of completing this form, except in those provinces where prohibited by statutory regulations. This form may be mailed directly to Co-operators Life Insurance Company at 1920 College Avenue, Regina, Saskatchewan S4P 1C4, or given to the patient at the physicians discretion.

HISTORY

Form containing history questions: Date symptoms first appeared or accident occurred, Date patient ceased work because of current condition, Date of first visit for present condition, Since first visit, how often have you seen this patient?, Date of next visit, Date of last visit, Has patient ever had same or similar condition?, Is condition due to injury or sickness arising out of patient's employment?, Is condition considered chronic?, Is condition due to injury or sickness arising out of patient's employment?, Has your patient been referred to any other physician/specialist?, Physician's/Specialist's Name, Specialty, Dates of Examinations, Summarize physician's/specialist's findings, Blood Pressure (last visit), Weight, Height.

DIAGNOSIS:

Form containing diagnosis questions: Primary, Other factors which may affect the duration of this disability: Addictions, Dietary, Psychosocial, Family, Employment, General Fitness, Pre-Existing Condition(s), The claimant previously had the same or similar condition. Yes, No, Please explain any of the above, Subjective symptoms, Objective findings, Investigations (e.g. EKG's, x-rays, lab tests, etc.), Date Carried Out, Summary of Results (Attach copies of all available reports.), Are any further investigations planned? Yes, No, If "Yes", state type and when., If condition is due to pregnancy, please give expected date of confinement.

PHYSICAL CAPABILITIES:

Form containing physical capabilities questions: What activities is the patient capable of doing on a regular basis?, Are you aware of the duties of your patient's job?, What restrictions prevent the patient from performing the duties of their job?

DISORDERS OF NECK OR BACK: EXAMINATION OF Neck Back

Form containing physical examination tables: A. Range of Motion (Normal, Pain, Limitation), B. Palpatory Tenderness? (Yes, No), E. Neurological Examination (Sensory deficit, Motor weakness, Decreased deep tendon reflexes).

Form containing diagnostic tests and low back injury sections: Diagnostic tests: Plain radiographs, Degenerative changes at level(s), Fracture/dislocation at level(s), Other radiographic findings; Diagnosis: Whiplash associated disorder (Grade I, II, III, IV); Low back injury: Grade I, II, III, IV.

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS - COMPLETE REVERSE SIDE OF THIS FORM.

**PSYCHOLOGICAL CAPABILITIES**

What is your patient's diagnosis according to the DSM-IV?  
 Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_ Axis IV \_\_\_\_\_ GAF - Current Date \_\_\_\_\_ GAF - Past Date \_\_\_\_\_

What psychometric testing has been performed? **Attach copies of all psychometric testing results, chart notes, treatment notes, and medical records.**

**Psychiatric Degrees of Impairment**  
 No Impairment (Functioning is generally adequate or normal for this claimant in any work setting)  
 Impairment Only in the Work Setting (Functioning is generally adequate for this claimant outside of the work setting)  
 Reason: \_\_\_\_\_

Are you aware of the duties of your patient's job?  
 \_\_\_\_\_

What major tasks of the patient's occupation is she/he able to perform?  
 \_\_\_\_\_

Unable to perform? (List specifics that impair functional activity.)  
 \_\_\_\_\_

Impaired (for each category circle only one item)

- activities of daily living
  1. some degree of difficulty encountered
  2. several everyday activities cannot be carried out without assistance or support. (basic personal care still unassisted).
  3. needs assistance with most routine daily activities. Significantly neglects personal care.
  4. requires substantial help with all activities of daily living.
- social functioning
  1. social interactions minimally disrupted
  2. easily upset or somewhat guarded (interaction minimal outside family/close friends)
  3. markedly withdrawn or uncommunicative even with immediate family. Overt hostility, obviously suspicious.
  4. uncommunicative or communicates in bizarre or unpredictably hostile manner
- concentration & pace
  1. task/functions performed adequately but with some degree of slowness or degree of agitation.
  2. relatively routine tasks performed with difficulty and effort. Obvious/notable slowness and agitation.
  3. incapable of sustaining attention on moderately complex tasks. Memory function is obviously impaired.
  4. unable to sustain attention for even simple tasks, disoriented, memory is severely impaired.
- coping
  1. coping is adequate but reacts to stress with some degree of anxiety or agitation.
  2. obvious difficulty applying usual coping skills, stresses reacted to with considerable anxiety or agitation.
  3. marked distress or anxiety to stress. Needs help coping with most complex or novel situations.
  4. extreme agitation, panic or marked regression in response to stress, or, exhibits persistent hallucinations or delusions.

Has there been psychiatric referral?  Yes  No If "No", please explain reasons.  
 \_\_\_\_\_

Remarks:  
 \_\_\_\_\_  
 \_\_\_\_\_

**CARDIAC (if applicable)**

**Please forward results of exercise stress tests, angiogram, or other relevant documentation.**

Based on the above assessment, the patient has:	Physical	Psychological	Cardiac
No limitation of functional capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slight limitation of functional capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate limitation of functional capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marked limitation of functional capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe limitation of functional capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**VISUAL IMPAIRMENT (if applicable)**

What was vision at latest observation?	With glasses	O.D. _____	O.S. _____	Vision can be restored in whole or in part by:	<input type="checkbox"/> O.D.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable
	Without glasses	_____	_____		<input type="checkbox"/> O.S.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable

**MANAGEMENT PLAN FOR THE CURRENT DISABILITY**

A. No active treatment required \_\_\_\_\_.

B. **Treatments** (Specify in each instance)  
 Medications  Exercise  Education  Other Treatment

The medications might impair safety in the workplace for the claimant or others.  Yes  No (Specify)  
 \_\_\_\_\_

Name of Medication	Dosage	Dates Initiated	Reason For Change In Medication (if applicable)

  

Date of any hospitalizations: From _____ To _____	Physiotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", frequency <input type="checkbox"/> Daily <input type="checkbox"/> 3 x per Week <input type="checkbox"/> Weekly <input type="checkbox"/> Other _____
	Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", type of surgery _____
	Date <input type="checkbox"/> Performed <input type="checkbox"/> Planned Day: [ ] [ ] [ ] Month: [ ] [ ] Year: [ ] [ ] [ ]

Describe any other treatment or future plans. (Specify with dates)  
 \_\_\_\_\_

Projected duration of treatment program:  
 \_\_\_\_\_

Summarize patient's response to treatment:  
 \_\_\_\_\_

Is patient following recommended treatment program?  Yes  No

**PROGNOSIS**

A. Activity Level  
 Is the patient currently: Working?  Yes  No Participating in activities of daily living?  Yes  No  
 Are there medical reasons for the person not to participate in normal activity including work?  Yes  No  
 If yes, describe:

The disability may affect activity for: \_\_\_\_\_# days if <8  8-14 days.  15-21 days. \_\_\_\_\_# days if >21 days  unknown  
**Have you discussed a return to work with your patient?**  Yes If "Yes", have you discussed a return to work at:  
 Own Occupation  Full-time Date  Part-time Date **OR**  
 New Job/Duties  Full-time Date  Part-time Date  
 No If "No", please explain.

What is being done to return your patient to work?

If a modified work plan is presented to you, including hours of work, physical restriction, modifications, could you agree?  
 Yes  No  
 Please detail restrictions:

Next appointment:  None Scheduled.

Comments:

**REHABILITATION:**

Is patient a suitable candidate for further medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)?  Yes  No If "Yes", specify.

Would vocational counselling and/or retraining be recommended?  Yes  No      Is patient attending a vocational assessment program?  Yes  No

Remarks - Please provide comments and further details which you feel would be helpful.

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Physician's Name (Print)	Specialty	Fax Number <input type="text"/>
Address		Telephone Number <input type="text"/>
Signature	Family Physician <input type="checkbox"/> Yes <input type="checkbox"/> No	Date



## APPLICATION FOR LONG TERM DISABILITY BENEFITS

### Employer's Statement

PLEASE PRINT

**Note:** After the employee completes his/her portion of this application, please certify current employment status and Long Term Disability coverage by completing and signing this portion of the application. If the employee appears to be entitled to Canada/Quebec Pension Plan Disability Benefits, have the employee submit an application.

Policy/ Plan No.	Account No.	S.I.N.	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Waiver Group Life Insurance Premium (if applicable)
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.				
last name			first name	

**CLAIMANT INFORMATION:**

Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	If age 60 or over, copy of birth certificate must be enclosed with claimant's statement.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/>
Address				
No. & Street	Suite/Apt. No.	City/Town	Province	Postal Code
Occupation: (State occupation held just before stopping work) 1. Is the employee currently absent for medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If the employee is absent for another reason (e.g., maternity leave, leave of absence), please give details.				
Is condition due to injury or illness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" has the employee applied for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No    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.

**COVERAGE INFORMATION:**

Date of employment:	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	Effective date of LTD coverage: With The Cooperators With the previous carrier	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	If employment now terminated, please indicate effective date:	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>
Date last worked:	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	Date expected to return to work:	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	Date returned to work:	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>
Class/Group/Union affiliation to which claimant belongs (if applicable) _____					
<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contract (please enclose a copy of the contract agreement)   Average hours worked per week _____ (excluding overtime) <input type="checkbox"/> Temporary <input type="checkbox"/> Commissioned   Is the employee involved in shift work? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what is the rotation schedule?)					

Please enclose copy of enrollment card.

**EARNINGS/BENEFIT INFORMATION:**

State employee's pay schedule: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually   Work Week i.e. Mon. - Fri. _____	
State rate of earned gross income immediately before stopping work, based on above pay schedule \$ _____ (exclude overtime, commissions and bonuses)	Date above rate became effective <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>
State payroll deduction immediately before stopping work, based on above pay schedule <b>* Please attach copy of paystub for last full pay period. *</b>	
Income Tax \$ _____	QPP/CPP \$ _____
EIC \$ _____	Pension (if applicable) \$ _____
RRSP (if applicable) \$ _____	
Is any portion of the LTD premium paid for by the policyholder/employer? <input type="checkbox"/> Yes (taxable) <input type="checkbox"/> No (non taxable)	
Current tax exemption per Federal TD1: \$ _____ (attach TD1).	
On what date did (or will) the employee's salary end? <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	
Does the employee currently receive remuneration from you? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes answer a & b below)	
a. How much? \$ _____ Per hour	Does this amount include unused sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Until what date will remuneration continue (including sick leave credits)? <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	

For commissioned or self employed provide T4, notice of assessment, and statement of expenses for previous two years.

**OTHER INCOME:**

<input type="checkbox"/> Sick pay    from <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> to <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	<input type="checkbox"/> Weekly Indemnity    from <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> to <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> Paid by (name source) _____	<input type="checkbox"/> Worker's Compensation    from <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> to <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> Status _____	<input type="checkbox"/> EIC    from <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> to <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> Status _____
<input type="checkbox"/> CPP/ QPP    Date applied <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small> Status _____			

**PENSION INFORMATION (if applicable)**

At the date of disability, was the employee a member of one of the following plans? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Defined Benefit Pension Plan <input type="checkbox"/> Defined Contribution Pension Plan <input type="checkbox"/> Group RRSP <input type="checkbox"/> Individual RRSP	
Administered by (name and address): (i.e. financial institution or organization)	
Note: If contributions made to Group or Individual RRSP, please provide copy of Locked-In Agreement.	
Date employee became or will become eligible to contribute: <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Day   Month   Year</small>	
Plan Name _____	Registration/Account Number _____
Contribution levels at date of disability    Employee _____%	Employer _____%
Total contributions made to the Plan this year    Employee _____\$	Employer _____\$

