HEALTHCARE BENEFIT TRUST HBT BENEFIT FROM EXPERIENCE

canada life™

Healthcare Benefit Trust (HBT) Policy #51337 ☐
Joint Community Benefits Trust (JCBT) Policy #59234 ☐
Joint Facilities Benefits Trust (JFBT) Policy #59233 ☐
Joint Health Science Benefits Trust (JHSBT) Policy #59232 ☐
Community Social Services Employers' Association (CSSEA) Policy #51367 ☐
Healthcare Benefit Trust (HBT) Policy #50168 ☐

Claim for Long Term Disability Benefits

STATEMENT OF CONTINUING DISABILITY – FORM D

Complete and return to Canada Life at the address indicated below:

☐ Vancouver: Suite #1500 – 1055 Dunsmuir Street, Vancouver, BC V7X 1K8
☐ Langley: Suite #500 – 19933 – 88th Avenue, Langley, BC V2Y 4K5
☐ Calgary: Suite #1700 – 530 8 Ave SW, Calgary, AB T2P 3S8

PLEASE PRINT

Division Number: | | | | **HBT Benefits ID No. (BID)** _____

Name: _____
Last First Initial

In order to assist us in the ongoing management of your claim, you and your doctor are required to complete, sign and return this form to us.

1. a) Have you returned to work since your last report? ☐ Yes ☐ No

If "Yes", when did you begin working? | | | | (Day Month Year)

Indicate: ☐ Full-time ☐ Part-time ☐ Usual Job ☐ New Job/Duties

If "No", do you anticipate returning to the workforce in the future? ☐ Yes ☐ No

b) Have you received any earnings since your last report? ☐ Yes ☐ No

c) Are you retraining or planning to do so? ☐ Yes ☐ No If "Yes", give details:

_____

_____

d) List any courses you have taken this year.

_____

_____

e) Have you done any volunteer work? ☐ Yes ☐ No If "Yes", give details:

_____

_____

2. Have you received, or are you receiving any other disability income? ☐ No ☐ Yes If "Yes", complete this section:

Type of Disability Income	**Monthly Amount**	**Commencement Date**	**Termination Date**
WorkSafeBC Claim #: _____			
ICBC Claim #: _____			
Canada Pension Plan Applied			
Other (e.g. legal actions, retirement benefits):			

(Canada Pension Plan Applied: Day | Month | Year)

Note: Attach copies of correspondence you have received related to the above.

AFTER COMPLETING PAGE ONE:

3. Take this form to your doctor and have them complete the following:

Does this patient continue to be under your care? ☐ Yes ☐ No

Reasons for continuation of disability: _____

_____

_____

Any complications/new conditions since your last report? ☐ Yes ☐ No

If "Yes", please comment

_____

_____

Physician's Name: _____ **Telephone Number:** _____

Address: _____

Street & Number Suite/Apt. No. City/Town Province Postal Code

Physician's Signature: _____ **Date:** _____

4. Read, sign and date below to continue your claim for disability benefits.

Protecting Your Personal Information

This section explains how your personal information will be used to administer your Long Term Disability (LTD) claim. The Trust and Canada Life respect your privacy and keep your personal information (including medical information) in confidential files. Only those who need your personal information to perform their duties, those to whom you grant access and those with a legal right to access your personal information will have such access. Any reference to "Trust" in this authorization section means one of the Trusts indicated on the first page, the Trustees of that Trust, their agents (including the Healthcare Benefit Trust where the Trust is not the Healthcare Benefit Trust) and Canada Life.

By signing this Form, I authorize the Trust to:

- collect, use and disclose my personal information (non-medical and medical), if reasonably necessary to (1) investigate, assess and/or administer my claim (including, but not limited to rehabilitation and return to work planning) or (2) administer the LTD Plan (including, but not limited to, auditing the LTD Plan). To clarify, I also authorize an exchange of my personal information among the Trust and its agents for those purposes;
- exchange my personal information (non-medical and medical) with any physician; health practitioner; healthcare or rehabilitation provider; independent medical examiner; any person who has or who may in the future, examine, treat or diagnose me; any hospital or clinic where I have or may become a patient; or any insurance company or any other organization with records or knowledge of me or my health, if the exchange is reasonably necessary to investigate, assess and/or administer my claim;
- exchange with my employer(s), my non-medical personal information as is reasonably necessary to investigate, assess and/or administer my claim or to assist my employer manage my absence, including rehabilitation and return to work planning. This may include information about my restrictions, limitations, abilities, and prognosis for rehabilitation and return to work.
- Claimants who are members of a union: Exchange with my union and/or bargaining association, my non-medical personal information as is reasonably necessary to assist my union and/or bargaining association to (1) represent me in respect of my claim, (2) bargain collectively in respect of the LTD Plan or (3) otherwise discharge its duties as my union/bargaining agent in respect of the benefits that are provided by the Trust including, without limitation, the Early Retirement Incentive Benefit program if it is part of the LTD Plan in which I participate.

By signing this Form, I declare that:

- my authorization will be effective until all aspects of my claim are complete including (but not limited to), the investigation, assessment and administration of my claim and any appeals, even if aspects occur after my benefits cease;
- I understand that the Trust must collect, use and disclose my Social Insurance Number to administer my claim;
- the statements I make on this Form and in the course of any personal or telephone interviews that relate to my claim, will be true and complete, and I understand that any benefits I receive are dependent on the truth of those statements.

Name *(please print):* _____ **Signature:** _____

Date: _____ **Telephone Number:** _____ **BID:** _____

Complete this section if your address or telephone number has changed since last report.

New Address: _____

Street & Number Suite/Apt. No. City/Town Province Postal Code

New Telephone Number: _____