HEALTHCARE BENEFIT TRUST
HBT
BENEFIT FROM EXPERIENCE

canada life™

Community Social Services Employers' Association
Early Intervention Program (CSSEIP)

CSSEIP Policy #51495/LTD Policy #51367

CSSEIP

CLAIMANT'S STATEMENT

To be completed by the Employee:

Part A: Employee Identification *(please print)*

1. Name: _____
Last First Initial

Address: _____
Number & Street City Province Postal Code

Telephone #s: Primary _____ ☐ Confidential
Secondary (Cell) _____ ☐ Confidential

Check the "confidential" box if you authorize Canada Life to leave a message containing personal information about your claim at that number.

Email Address: _____

Include your email address in order that Canada Life can communicate with you by secure email about your LTD claim.

2. Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other

3. Date of Birth _____ _____ _____
Day Month Year

4. Job Title: _____

5. Union (*if applicable*): _____

6. Collective Agreement: _____

Part B: Employer Contact

7. Employer: _____

8. Department/Program: _____

9. Name of employer contact: _____

10. Work relationship: _____
Manager, Disability Management Advisor, Supervisor, etc.

11. Telephone #: _____ **12. Email address:** _____

Part C: Protecting Your Personal Information

1 Purpose of Collection, Use and Disclosure

If you experience a Work Disability, you may access resources and programs that are designed to assist you to return to gainful employment. You are covered by the Healthcare Benefit Trust (Trust) which provides your Long Term Disability Plan (LTD Plan). Your LTD Plan includes this Early Intervention Program, through which Rehabilitation Services are delivered.

To administer this Early Intervention Program the Trust collects, uses and discloses your Personal Information and Diagnostic Medical Information and exchanges that information with its agents including Canada Life and other entities. More specifically, if you experience a Work Disability, the Trust will collect, use and exchange your Personal Information and Diagnostic Medical Information as is reasonably necessary to satisfy one or more of the following purposes: deliver Rehabilitation Services; help you manage your Work Disability if you are at work; if you are absent from work, confirm the anticipated duration of your leave and assist you and your employer to manage your absence from work; determine the type of work that is suitable given your functional limitations; determine if medical or vocational rehabilitation would benefit you and your return to gainful employment; and/or assist a Working Group to deliver services to you in respect of your Work Disability, if appropriate. If you make a claim for benefits from the LTD Plan (which requires that you complete an additional authorization form), this permits a transfer of information to administer that claim; and/or permits a collaboration among the Trust, its agents (including Canada Life), Health Care Providers, other service providers including those retained by the Trust to provide Rehabilitation Services, WorkSafeBC, ICBC, Working Groups and your employer as is reasonably necessary to fulfill the purposes set out herein.

2 Definitions

- **"Diagnostic Medical Information"** means diagnostic information about the illness or injury for which Rehabilitation Services may be provided or for which benefits from the LTD Plan may be claimed.
- **"Health Care Providers"** means a physician (doctor), therapist, or other medical practitioner who has or may examine, diagnose or treat you with respect to the illness or injury for which Rehabilitation Services may be provided or for which benefits from the LTD Plan may be claimed.
- **"Personal Information"** means information about you including without limitation, your name, address, date of birth, date of onset of Work Disability and information about your illness or injury (including, without limitation, information about your functional abilities, treatment or medication that may affect your return to work, nature of illness or injury and likely duration) but excluding Diagnostic Medical Information.
- **"Rehabilitation Services"** means customized services provided to ill or injured employees to facilitate safe stay at work and/or timely recovery and return to employment (including the provision of medical and vocational rehabilitation and return to employment services).
- **"Work Disability"** means an absence from work or a reduction in work capacity (e.g., reduction in hours or duties) attributed to an illness or injury.
- **"Working Group"** means a group created pursuant to a collective agreement (where applicable) to deliver early intervention and return to work services, comprised of representatives of your union and employer including the Early Intervention Coordinator.

3 Authorization for Collection, Use and Disclosure

I, _____ **authorize the Trust to:**
(Print Name)

- collect, use and exchange my Personal Information and my Diagnostic Medical Information with the Trust, its agents (including Canada Life), my Health Care Providers, other service providers, WorkSafeBC, ICBC and a Working Group, all as described in Section B1, as is reasonably necessary to fulfill any of the purposes outlined in Section B1; and
- disclose my Personal Information (excluding Diagnostic Medical Information) to an individual within my employer authorized to respond to Work Disabilities.

I, _____ **authorize my employer** _____
(Print Name) (Employer Name)

to disclose:

- my Personal Information and my Diagnostic Medical Information to the Trust and its agents (including Canada Life), as is reasonably necessary to fulfill any of the purposes outlined in Section B1.

I, _____ **confirm that:**
(Print Name)

- this authorization will be effective until all aspects of the Early Intervention Program are complete and, if I make a claim for benefits from the LTD Plan, until all aspects of that claim are complete (including, but not limited to, the investigation, assessment and administration of such a claim and any appeals), even if some aspects occur after cessation of the Early Intervention Program and/or benefits from the LTD Plan;
- this electronic version of this form shall be as valid as a copy of this form signed by me in person; and
- I agree to the collection, use and disclosure of my Personal Information as set out in this form.

Signature _____ **Date** _____
(MM/DD/YY)

Name _____
(Print)

Email or fax completed form to the appropriate Canada Life Disability Management office: Calgary: calgary.dmso@canadalife.com, fax: 1.877.486.7894 | Langley: langley.dmso@canadalife.com, fax: 1.844.569.3131 | Vancouver: vancouver.dmso@canadalife.com, fax: 1.844.816.1038

If you are unable to email, documentation may be submitted by mail and should be directed to the Canada Life Assurance Company: PO Box 1055, Winnipeg, MB R3C 2X4