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

EMPLOYEE REFERRAL FORM

To be completed by the Employer:

STEP I
Ensure all Qualification Criteria are met

STEP II
Complete Employer Assessment

STEP III
Submit Employee Referral & Claimant's Statement to Canada Life at the appropriate office:

Calgary: calgary.dmso@canadalife.com or fax 1.877.486.7894

Langley: langley.dmso@canadalife.com or fax 1.844.569.3131

Vancouver: vancouver.dmso@canadalife.com or fax 1.844.816.1038

STEP I - QUALIFICATION CRITERIA

The following must be met in order for Canada Life's Rehabilitation Services to process the referral:

- ☐ Employee's authorization is received by Canada Life
- ☐ Employee is eligible for enrolment in the LTD Plan
- ☐ A **work disability*** is present that could result in an LTD claim
- ☐ "Employer Assessment" section is completed (next page)
- ☐ The employee's return to **employability**** may be expedited by rehabilitation
- ☐ Ideally, the referral is made at least **45 days***** prior to the LTD qualification date

* **Work Disability:** An absence from work or a reduction in work capacity (e.g., reduction in hours or duties) attributed to an illness or injury.

** **Employability:** Ability to perform gainful employment, i.e., an occupation for which the Employee has the education, training and/or experience at a rate of pay defined by the Employee's LTD plan.

*** Please contact Canada Life if the referral is less than 45 days prior to the LTD qualification date.

EMPLOYEE INFORMATION/CONTACT

Name	Position Title	Facility	HBT Div #	Birthdate (D/M/Y)

Employment Status	FTE	Hourly Pay Rate	HBT Benefits ID No. (BID)	Collective Agreement *(if applicable)*	Class Code	Union

Date of Hire (M/D/Y)	Work Status	WSBC Status	Last Day Worked (M/D/Y)	First Day Absent (M/D/Y)

Home address:

Apt#	Street	City	Postal Code

Phone #	Alternative Phone #	Email Address

PHYSICIAN CONTACT

Doctor	Phone #	Street	City

EMPLOYER INFORMATION

Referred by (Name)	Title	Phone #	Email Address

Employer/Workplace Name

Street	City	Postal Code

Date

STEP II - EMPLOYER ASSESSMENT

1. Provide general information on the nature of the **work disability*** *(include: the diagnosis, copies of medical information gathered to date, dates of upcoming medical appointments/specialist referrals if known, Doctors name(s), return to work dates, current medical treatment plan, prognosis, etc.)* Please ensure that you include copies of all relevant information where available).

2. Describe the specific requirements of the job and outline the current functional abilities compared with the tasks that the employee cannot complete and outline any restrictions and/or limitations *(include Job Demands Analysis and/or Functional Abilities Evaluation, if available)*.

3. Describe any work arrangements that have been tried *(e.g., adjusted work hours, modified duties, etc.)*.

4. Describe any history related to the absence and/or HR/LR involvement *(e.g., absenteeism, sick time usage, attendance management program, change in performance, poor performance, date and observations around when employee began to struggle at work, safety and/or behaviour concerns, etc.)*.

5. Specify any barriers *(i.e., medical, personal, vocational and/or workplace)* and impacting factors that have been identified or observed and whether and/or how these have been addressed with the individual.

Additional Employer Comments and Current Case Management Plan *(where available)*

Expenditures for rehabilitation from Trust funds can be authorized only when there is evidence of LTD cost savings, as per the Cost Benefit Analysis completed by the Rehabilitation Consultant

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