THE
Great-West Life
ASSURANCE COMPANY

London Disability Management Services
255 Dufferin Avenue L1104
London ON N6A 4K1
Canada

Tel 519.432.7229 / 1.866.325.6413
Fax 1.844.816.1040
london.dmso@gwl.ca

RECEIVED
JAN 23 2018

January 16, 2018

MS. Joanne Cheechoo
Finance Assistant
Nishnawbe Aski Legal Services
86 South Cumberland St
Thunder Bay, ON P7B 2V3

Dear MS. Cheechoo:

RE: KEITH WILLIAM MCKAY
Nishnawbe-Aski Legal Services
Group Plan Number 106790
Employee ID Number E000000137
Portfolio ID 123878110

We have approved Mr. MCKAY's claim for Short Term Disability (STD) benefits to January 7, 2018. Benefits continue to this date as long as the STD definition of disability and all other requirements of your group STD plan remain satisfied.

Mr. MCKAY will receive a separate letter explaining this decision.

Great-West Life's assessment is based on available information and under the terms of your group plan. Great-West Life's decision should not be relied upon for any other purpose.

Payment details
There is a 7 day waiting period before benefits begin. The waiting period starts on November 9, 2017 and ends on November 15, 2017. Benefits begin on November 16, 2017.

The weekly benefit amount is $585.00.

Other information
Please call me at 1-866-325-6413, extension 4882 if you learn anything that would affect the duration of this claim or have questions about the claim.

You can contact your Great-West Life Client Service Representative if you have any questions regarding premiums and continuing coverage.

Jeff Robert

From: Keith McKay <kmckay@nanlegal.on.ca>
Sent: February-21-18 11:36 AM
To: jrobert@nanlegal.on.ca
Subject: Thank You , Sir.

Jeff Roberts. Regarding the overpayment with my Employer. I wish to inform you to go ahead and deduct my pay checks starting payroll dates on March, 08 and March, 22 and a Finally payment on April, 05 the amounts of $ 905.45. each pay days.

Thank You

Keith William John Mckay .

Paycode History Detail By Employee

End Dates From Apr 3, 2017 To Feb 28, 2018

Period End	Release Straight Hours VP 4wks ac	Release Total Hours VP 4wks ac
MCKAY, KEITH WILLIAM JOHN		
May 26, 2017	2.00	2.00
Jun 9, 2017	2.00	2.00
Sep 1, 2017	2.00	2.00
Oct 13, 2017	5.00	5.00
Feb 2, 2018	2.00	2.00
MCKAY, KEITH WILLI/	13.00	13.00
REPORT TOTALS	13.00	13.00

$4429.29 / 22.2747/hr

40.64

= 198.8485
(76.9)
121.9485

Nov 16 – Jan 7

4.7 - vac = 121.9485 / 3

x 7 /day

53.9 tot. vac

2 Lieu

21.08 sick

76.9 total hours

= 40.6499

next days

(stairs) = flight of stairs
- No high energy
- ice

Nishnawbe-Aski Legal Services Corporation

Fax Cover
Kasabonika Youth Intervention
(FAX # 807 -535-9211)

Date: Feb, 09/2018

To: Jeff Roberts

Fax: 1-807-622-3024

From: Keith McKay

Re: Great West Life.

Message:

Please Review.

We are transmitting the following 04 pages(including this cover letter). If you do not receive all pages, please call us as soon possible.

Telephone: 1-807-535-9252 Fax: 807-535-9211

Contact: Keith

The Great-West Life
ASSURANCE COMPANY

London Disability Management Services
255 Dufferin Avenue L1104
London ON N6A 4K1
Canada

Tel 519.432.7229 / 1.866.325.6413
Fax 1.844.616.1040
london.dmso@gwl.ca

January 16, 2018

Mr. KEITH WILLIAM MCKAY
Lot #104
Kasabonika, ON P0V 1Y0

RE: Nishnawbe-Aski L[illegible] Services
Group Plan Number 106790
Employee ID Number E000000137
Portfolio ID 123878110

We are writing to let you know that your claim for Short Term Disability (STD) benefits has been accepted to January 7, 2018.

This letter explains your benefits, including:

- Your payment details
- Definition of disability
- Your responsibilities

Your payment details
Under your STD plan, there is a 7 day waiting period before benefits begin. This waiting period starts on November 9, 2017 and ends on November 15, 2017. Your benefits will begin on November 16, 2017.

You will receive a weekly benefit of $585.00. This is based on 75% of your weekly salary of $779.62.

Your first benefit payment for the period November 16, 2017 to January 7, 2018 will be issued shortly. You can expect future payments to be issued weekly.

Income tax will be withheld from your benefit payments. We will send you a T4A slip by February 28 to include in your annual tax return.

Definition of disability
The terms of your plan state that:

Disability is assessed on the basis of the duties you regularly performed for your employer before disability started. You are considered disabled if, because of disease or injury, there is no combination of duties you can perform that regularly took at least 60% of your time at work to complete.

Your responsibilities
Your plan requires you to participate and cooperate with reasonable and customary treatment

To help us monitor your con[illegible]on, we will ask for information from [illegible] and your physicians from time to time. Please let us know of any changes in your medical status and treatment so we can request updated reports at appropriate times.

Additional information

We recommend that you keep this letter for your records as it contains a lot of information. If you have any questions or concerns, please feel free to call me at 1-866-325-6413, extension 4882.

Sincerely,

Emma S.
Case Manager

REF: 788048898-123878110/ MCKAY03859L

You and your family deserve
a great service experience.
We are committed to delivering that experience to you – every time.
The Great-West Life Assurance Company
www.greatwestlife.com

Keith Mckay
Lot #104
Kasabonika, ON.
P0V 1Y0

Your group coverage with
Nishnawbe Aski Legal Services
Division 1
Your plan number 106790
Your I.D. number E000000137

Claimant's Explanation of Benefits January 17, 2018

Your Short Term Disability benefit for the period November 16, 2017 - January 7, 2018 is:

$ 585.00 weekly for 7 weeks and 4 days	$ 4,429.29
Payment	$ 4,429.29

Payment no. 62844887 for $ 4,429.29 paid to you

Benefits for this claim have now been paid for 7 weeks and 4 days

Please keep all information contained here secure. If you have any questions, please contact The Great-West Life Assurance Company, London Dmso, 255 Dufferin Avenue L1104, London, ON., N6A 4K1, or call 866-325-6413.

Copy to: Nishnawbe Aski Legal Services

DIRECT DEPOSIT ADVICE

The amount $4,429.29 will be deposited directly into your account 399XXXX,

your financial institution

If any of the above banking information has changed, please advise Great-West Life.
With normal bank clearing procedures the deposit will appear in this account within the next few days.

NOT NEGOTIABLE **NON NEGOCIABLE**

THE
Great-West Life
ASSURANCE COMPANY

January 17, 2018

Plan Administrator's Explanation of Benefits

Re: Keith Mckay
Group coverage with
Nishnawbe Aski Legal Services
Division 1
Plan Number 106790
I.D. Number E000000137

The Short Term Disability benefit for the period November 16, 2017 - January 7, 2018 is:

$ 585.00 weekly for 7 weeks and 4 days	$ 4,429.29
Payment	$ 4,429.29

62944887 for $ 4,429.29 paid to Keith Mckay

Benefits for this claim have now been paid for 7 weeks and 4 days

Please keep all information contained here secure. If you have any questions, please contact The Great-West Life Assurance Company, London Dmso, 255 Dufferin Avenue L1104, London, ON., N6A 4K1, or call 866-325-6413.

Copy to: Keith Mckay

Nishnawbe-Aski Legal Services
Corporation

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ᒪᐦᓯᑕᒪᓱᐎᓐ

Fax Cover

Date: Jan 9/18

To: MSO

Fax: 844-816-1040

From: Jeff Robert

Re: Keith McKay

Message:

We are transmitting the following 58 pages (including this cover letter). If you do not receive all pages, please call us as soon as possible.

Telephone: 1-800-465-5581 Fax: 807-622-3024

Contact: ______

THE INFORMATION CONTAINED IN THE TELECOPY IS INTENDED FOR THE USE OF THE RECIPIENT ABOVE. The telecopy may contain privileged, confidential, or undisclosed information. If the reader of this telecopy is not the intended recipient, you are hereby notified that you have received this telecopy in error, and that any review, dissemination, distribution, or copying of it is strictly prohibited. If you have received this in error, please notify us immediately by telephone and return the original transmittal to us by mail. Thank you for your cooperation.

Mailing Address:

86 S. Cumberland Street
Thunder Bay, Ontario
P7B 2V3

Tel: (807) 622-1413
Fax: (807) 622-3024

Email:
info@nanlegal.on.ca

Website:
www.nanlegal.on.ca

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

Head Office:

109 Mission Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1K7

844-816-1040
DM80

THE
Great-West Life
ASSURANCE COMPANY

Disability Income Benefits
Short Term Disability
Employer Statement

The Employer's and Employee's Statements should be completed and sent to Great-West Life within 5 days of the onset of the disability. Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee. **Ensure all sections are completed to prevent any delay in assessing this claim.**

Company Name: Nishnawbe Aski Legal Services   Plan Number: 106790

EMPLOYEE IDENTIFICATION

First Name	Middle Initial	Last Name	Great-West Life ID Number	Division	Class
Keith	W	McKay	137	1	2

Date of Birth (MM/DD/YY)	If plan is taxable provide Social Insurance Number	Home Phone Number	Cell Phone	Work Phone
01/14/57			8072126283	8075359252

Home Address	City/Town	Province	Postal Code
Lot $104	Kasabonika	ON	P0V 1Y0

EMPLOYMENT INFORMATION

Job title: Community Youth Intervention Worker   Effective date of hire: 07/04/11 (MM/DD/YY)

Employee's gross earnings prior to disability: 40539.98 ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-Monthly ☐ Monthly ☑ Annually

Employee is:
a) ☑ Full-Time ☐ Part-Time
b) ☑ Permanent ☐ Temporary ☐ Seasonal ☐ Contract
c) ☑ Hourly ☐ Salaried ☐ Commissioned ☐ Salaried and Commissioned ☐ Hourly and Commissioned
☐ Other Description: ____

Regular number of scheduled hours: 35 ☑ Weekly ☐ Bi-weekly ☐ Monthly

Do the scheduled hours vary (excluding overtime)? ☐ Yes ☑ No

Is the employee still employed? ☑ Yes ☐ No Date employment ended: ____ (MM/DD/YY)

COVERAGE INFORMATION

Date the employee signed their application for group coverage: 07/26/11 (MM/DD/YY)

Date the employee became covered under the plan: 10/26/11 (MM/DD/YY)

Basic disability coverage amount for the employee: 585 every week

Does the employee have any excess STD insurance? ☑ No ☐ Yes Amount of excess STD insurance ____

EMPLOYEE TAX INFORMATION

TD-1 personal tax credits: ____ **OR** Quebec TP-1015.3 source deductions: ____

Is the employee exempt from tax under the Indian Act (CRA form TD1-1N)?
☐ No
☑ Yes What percent of the employee's income is tax exempt? 100 %

M5453-10/17

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EMPLOYEE TAX INFORMATION (con't)

The following must be completed if your plan is Administrative Services Only (ASO) AND you have authorized Great-West Life to deduct CPP/QPP and EI/QPIP from the employee on your behalf.

Employee's province of employment: ____________

Enter the following amounts you deducted from your payroll system based on wages you paid:

Year-to-date CPP / QPP Contributions: ____________ Year-to-date EI Premiums: ____________ Year-to-date QPIP Premiums: ____________

Year-to-date Pensionable Earnings: ____________ Year-to-date Insurable Earnings: ____________

ABSENCE INFORMATION

Employee's last day of work: 11/08/11 (MM/DD/YY) Percentage of day worked on last day ______ %

Employee's first day absent from work: 11/09/11 (MM/DD/YY)

Have you paid the employee beyond their last day of work?

☐ No ☐ Yes Date employee paid to: ____________ (MM/DD/YY) OR ☑ Ongoing

Type of pay: ☐ Sick Pay/Salary Continuance ☐ Vacations Days ☑ Other

What is the reason for the employee's absence from work? *Select all that apply:*

☑ Medical

☐ Strike

☐ Temporary Lay-off Start date ____________ (MM/DD/YY) Recall date (if known) ____________ (MM/DD/YY)

☐ Maternity Leave of Absence Start date ____________ (MM/DD/YY) Planned end date ____________ (MM/DD/YY)

☐ Leave of Absence Start date ____________ (MM/DD/YY) Planned end date ____________ (MM/DD/YY)

☐ Other ____________

Is the absence due to a work related incident?

☑ No ☐ Yes Has a worker's compensation claim been filed? ☑ No ☐ Yes

Has the employee returned to work?

☐ No When do you expect the employee to return to work? ____________ (MM/DD/YY) OR ☐ Unknown

☑ Yes Date returned to work: 01/08/11 (MM/DD/YY)

The employee first returned to *(select all that apply)*: ☑ Regular duties and hours ☐ Modified duties ☐ Modified hours

Were there any workplace issues leading up to the employee's absence? ☐ Yes ☑ No ☐ Unknown

Do you anticipate any difficulties with the employee's return to work? ☐ Yes ☑ No ☐ Unknown

Do you have any concerns with this employee's claim for disability benefits? ☐ Yes ☑ No ☐ Unknown

If yes or unknown to any of these questions, please explain. *A Great-West Life claim representative may contact you to discuss further.*

DECLARATION

☑ I declare the information I've entered is accurate. Today's Date (MM/DD/YY): 01/09/18

Name of Contact Person: Jeff Robert

Job Title: HR Generalist

Phone Number: 807-766-7074

Email Address: jrobert@nanlega.on.ca

Confidential Fax Number: ____________

Address: 86 Cumberland St S

City/Town: Thunder Bay

Province: ON

Postal Code: P7B 2V3

Authorized Signature:

If submitting form by fax or email, the Authorized Signature field must be signed.

If submitting form online, online certification will be applied.

THE
Great-West Life
ASSURANCE COMPANY

Job Questionnaire

EMPLOYEE IDENTIFICATION

First Name	Middle Initial	Last Name	Plan Number	Great-West Life ID Number
Keith	W	McKay	106790	137

JOB INFORMATION - part 1

Employee's job title as of last day worked: Community Youth Intervention Worker

How would you classify the physical requirements of the employee's duties?

☑	Limited	Work activities involve handling loads up to 5 kg. For example: • Examining and analyzing financial information. • Administering and marking written tests.
☐	Light	Work activities involve handling loads up to 5 kg, but less than 10 kg. For example: • Repairing soles, heel and other parts of footwear. • Filing materials in drawers, cabinets and storage boxes. • Preparing and cooking meals.
☐	Medium	Work activities involve handling loads between 10 kg, but less than 20 kg. For example: • Measuring, cutting and applying wallpaper to walls. • Adjusting, repairing or replacing mechanical or electrical components using hand tools and equipment.
☐	Heavy	Work activities involve handling loads more than 20 kg. For example: • Shoveling cement into cement mixers and assisting in the maintenance and repair of roads. • Measuring, cutting and fitting drywall sheets for installation on walls and ceilings. • Operating power saws to thin and space trees in reforestation areas.

How long has the employee worked in this position? 6 Years 5 Months

Did you make any changes to the employee's job duties prior to their absence as a result of their medical condition? ☐ Yes ☑ No

If yes, please explain:

JOB INFORMATION - part 2

You do not have to complete part 2 if the employee has returned to work or the absence will be less than 4 weeks.

Physical and Cognitive Demands

If you have documentation that outlines the physical and/or cognitive job demands you do not need to complete the section(s) below.

I will send a separate document outlining the: ☐ Physical job demands ☐ Cognitive job demands

Lifting/Carrying - *Select the option that describes how often they are lifting/carrying during their normal work day*

Weight	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
up to 100 lbs / 45 kg	☑	☐	☐	☐
up to 50 lbs / 22.75 kg	☑	☐	☐	☐
up to 20 lbs / 9.1 kg	☑	☐	☐	☐
up to 10 lbs / 4.5 kg	☑	☐	☐	☐

Mobility - *Select the option that describes how often they are performing each activity during their normal work day*

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Reaching	☐	☑	☐	☐
Bending or crouching	☐	☑	☐	☐
Kneeling or crawling	☑	☐	☐	☐

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Endurance - *Select the amount of time they are required to remain in an activity before changing to a new activity. In the last column indicate the total hours they are required to be in that activity during the course of their normal work day.*

Activity	0-30 Minutes	31-60 Minutes	61-90 Minutes	> 90 Minutes	Total time per day
Sitting	☐	☐	☑	☐	3.5 Hours
Standing	☐	☐	☑	☐	2.5 Hours
Walking	☐	☐	☑	☐	1 Hours
Climbing	☑	☐	☐	☐	____ Hours
Driving	☑	☐	☐	☐	____ Hours

Cognitive Job Demands - Select the option that describes how often they are performing each activity during their normal work day

Activity	None	Occasionally (up to 33%)	Frequently (34%-66%)	Constantly (67%-100%)
Attention to detail	☐	☐	☑	☐
Multi tasking	☐	☐	☑	☐
Analysis	☑	☐	☐	☐
Verbal communication	☐	☐	☐	☑
Reading/Writing	☐	☑	☐	☐
Memory	☐	☐	☑	☐
Supervision of others	☐	☐	☑	☐

ADDITIONAL INFORMATION

Please provide any additional information that you believe should be considered in assessing the employee's claim.

As a youth intervention worker, Keith has the ability to schedule his day as to what will suit his needs for the day. His job duty are to have activities for the youth (up to 18yrs old) in the community.

DECLARATION

☑ I declare the information I've entered is accurate.

Today's Date (MM/DD/YY): 01/09/18

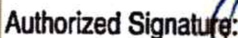
Name of Contact Person
Jeff Robert

Job Title
HR Generalist

Phone Number
807-766-7074

Email Address
jrobert@nanlegal.on.ca

Confidential Fax Number



Authorized Signature:

If submitting form by fax or email, the Authorized Signature field must be signed.

If submitting form online, online certification will be applied.

Sioux Lookout Meno Ya Win Health Centre

SIOUX LOOKOUT
Meno Ya Win
HEALTH CENTRE

CONSULTATION REPORT

SL AC N

Name: MCKAY,WILLIAM JOHN
MRN: SL00011787
Account: SA070321/17
DOB: 14/01/1957
HCN: 3057748901-VK
Residence: KASABONIKA
Band #: 148
Band Name: KASABONIKA LAKE
Family Physician: AARON ROTHSTEIN MD
Admission / Service Date: 23/11/17
Address: BOX 133, KASABONIKA, ON, P0V 1Y0
Phone: 807-535-9175

DATE DICTATED: November 27, 2017

INFECTIOUS DISEASE CONSULTATION

REASON FOR CONSULTATION: Right total knee arthroplasty prosthetic joint infection, secondary to group A strep.

CURRENT ANTIMICROBIALS:
Cefazolin 2g IV q.8 since November 15, 2017.
Previously ertapenem and vancomycin since November 8, 2017.

CLINICAL COURSE: Sometime in the early fall, Mr. McKay, a 60-year-old man sustained a scratch while walking around in the bushes. He did apply some Polysporin, but noticed increasing redness spreading up his legs. He eventually collapsed one day onto his right leg being unable to weightbear due to pain. I am not clear whether he was systemically unwell at the time, but eventually was medevac'd out to Sioux Lookout Meno Ya Win Hospital for assessment. There, he was noted to have a violaceous rash on the leg which was also quite tender as well as a swollen knee. Joint aspirate was performed which led to the diagnosis of group A strep, wound culture prior to that had also grown group A strep. He was empirically treated with vancomycin and ertapenem, then transferred down to Thunder Bay Regional Health Sciences Centre for operative management of his prosthetic joint. On November 11, 2017, he underwent an irrigation and debridement, right knee synovectomy and liner exchange of his right TKA. He was subsequently switched to cefazolin.

He has a PICC line in. He is doing quite well, noticing decreasing pain and is able to weightbear and participate in physiotherapy. He is quite keen on returning home to his community within the next 2 weeks well before the likely suggested time course for his antibiotics.

He denies any adverse effects.

PAST MEDICAL HISTORY: Type 2 diabetes.

ALLERGIES: ACETAMINOPHEN, PRODUCING RASH.

EXAMINATION: He is alert and oriented. There are some limitations to extension of his right knee which is still somewhat swollen. He has a dried blistering rash on the anterior surface of his leg with some old blisters that appear to have been hemorrhagic on the dorsum his foot and

interspersed on his right lower extremity. There is still edema to his leg. The joint is warm and diffuse, although he tells me this is much better from previous. There is only mild joint line tenderness. The surgical scar looks intact, there is no drainage.

INVESTIGATIONS: WBC is 10, hemoglobin 120 and platelets 373. Creatinine is 91. Wound cultures from November 7, 2017, show group A strep and pure growth. Blood cultures November 7, 2017, were negative x 1. Synovial fluid on November 8, 2017, showed growth of group A strep likewise and repeat synovial fluid cultures on November 10, 2017, were negative. Intraoperative tissue samplings were negative x 2 and a mycobacterial culture had also been sent with negative AFB on staining, with final culture results still pending.

Thank you for involving me in the care of this patient.

Sincerely,

Yoko Schreiber, MD

DICTATED BUT NOT READ

YOKO SCHREIBER MD RCPSC

cc: AARON ROTHSTEIN MD
LUCY MANCHESTER MD
MARY ENGLAND MD
YOKO SCHREIBER MD

D: 27/11/17 1716 SCHRY
T: 28/11/17 0750
2811-0021

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
980 Oliver Road,
Thunder Bay, ON P7B 6V4

OPERATIVE REPORT

Location:	T 3B SURG	MRN:	TB00754067
Admission / Service Date:	10/11/17	Patient:	MCKAY,WILLIAM JOHN
Account:	TB209746/17	DOB:	14/01/1957
Dictated By:	KURT DROLL MD FRCS (C)		

DATE OF PROCEDURE
November 11, 2017

PROCEDURAL DOCTOR
Dr. K. Droll

ASSISTANT
Dr. W. Neilipovitz
Dr. R. Farmer

ANAESTHETIST
Dr. S. Bonneville

ANAESTHETIC
General.

PREPROCEDURE DIAGNOSIS
Septic right total knee arthroplasty.

POSTPROCEDURE DIAGNOSIS
Septic right total knee arthroplasty.

PROCEDURE
Right knee synovectomy, irrigation and debridement right knee, liner exchange right total knee arthroplasty.

IMPLANT EXCHANGED
Liner size G 12 cruciate-retaining polyethylene.

PROCEDURE NOTE
The patient was brought to the Operating Room and given a general anesthetic. Perioperative antibiotics were administered. A tourniquet was placed on the right leg, and the right leg was prepped and draped in standard sterile fashion.

A double knife was used to remove the pre-existing scar. An anterior longitudinal arthrotomy was performed. We did encounter purulent fluid. This was swabbed and sent to the Lab. We continued to release the fibrous tissues so that we could evert the patella. We were able to identify the synovium, and a full synovectomy of the knee was performed. Samples were sent to the Lab for culture.

We then removed the liner, which also facilitated further mobilization of the knee. Further debridement of the posterior capsule was performed. Since this was a cruciate-retaining implant, we did not debride the PCL.

We then irrigated the knee and brushed the components. We copiously irrigated with at least 6 litres of sterile saline. At the conclusion of the irrigation, we then dried the knee. We trialed different polyethylene

sizes, and were pleased with the same size that was removed. Therefore, we placed a size 12 cruciate-retaining polyethylene into the knee without difficulties.

There was a fair amount of synovium that had grown over the patella. We did excise, certainly at the periphery of the patella, hyperplastic synovium. The patella tracked satisfactorily.

The knee was irrigated again prior to closure. #1 Vicryl was used to close the arthrotomy, 2-0 Vicryl was used to close the subcutaneous tissue, and the skin was closed with staples. A sterile dressing was applied.

The patient tolerated the procedure well, and was stable to Recovery.

AUTHENTICATED BY:
KURT DROLL MD FRCS (C)

cc: BONNIE WOOLFORD MD
KURT DROLL MD

D: 12/11/17 1651 DROLK
T: 14/11/17 1555 LK
1411-0470

Dec 19/17

Nishnawbe Aski Legal Services Corporation

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Mailing Address:

86 S. Cumberland Street
Thunder Bay, Ontario
P7B 2V3

Tel: (807) 622-1413
Fax: (807) 622-3024

Email:
info@nanlegal.on.ca

Website:
www.nanlegal.on.ca

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

Head Office:

109 Mission Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1K7

Fax Cover

Date: Dec 19/17

To: GWL Short term Disability

Fax: 1 844-816-1040

From: Jeff Robert

Re: Keith McKay

Message:

Policy 106790

~~ID~~ ~~137~~ 137

We are transmitting the following 17 pages (including this cover letter). If you do not receive all pages, please call us as soon as possible.

Telephone: 1-800-465-5581 Fax: 807-622-3024

Contact: ______________________

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Short Term Disability Income Benefit

Employee's Guide

THE
Great-West Life
ASSURANCE COMPANY

Short Term Disability Income Benefits

This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within ten days of the onset of your disability. Your notice form, and any other correspondence you may wish to provide about your claim, should be submitted to the Great-West Life disability management services office assigned to assess your claim. Should you wish to submit your notice form directly to Great-West Life, please contact your employer for the appropriate mailing address.

1. Employee's Statement

The Employee's Statement asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your **Group Plan Number.**

2. Authorization Request

We need your permission to obtain information that will help us assess your claim. By signing this authorization request, you give Great-West Life permission to obtain this information from your doctor, your employer, other insurers and hospitals where you received treatment.

3. Attending Physician's Report

Ask your doctor to complete this form. It requests general information about your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance coverage began, your job duties and earnings. We have asked your employer to supply this information directly to us.

Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

THE Great-West Life ASSURANCE COMPANY

Short Term Disability Income Benefits Employee's Statement

NOTICE OF CLAIM

Note: If you have Guaranteed Standard Issue Program coverage with Great-West Life, this form will be used as notice of claim for that coverage as well.

Identification

1. ☒ Mr. ☐ Mrs. ☐ Ms.

Your Name: First William Initial J. Last McKay

Address: Street & Number Lot. #104

City Kasabonika Province ON Postal Code P0V 1X0

Telephone: Home ( ) ☐ Confidential Work (807) 5359252 ☐ Confidential

Cell (807) 2126283 ☐ Confidential

If you wish us to leave a detailed message with personal information about your claim at a number, check the box marked "confidential" beside that number. Otherwise, we will only leave a general message with callback information at that number.

Email address: Kmckaye.nanlegal.on.ca

If you would like Great-West Life to communicate with you by email about your disability claim, please fill in your email address. Emails Great-West Life sends to this address will be sent securely using Proofpoint Secure Email.

* 2. Your GWL Employee Identification Number 137

Your Identification number must be completed. If unknown, please check with your employer.

3. Social Insurance Number 457 264 570

If your employer pays for all or any part of your disability benefits coverage, any benefits payable may be subject to income tax. If this applies to you, please provide your Social Insurance Number for income tax reporting purposes. Your Social Insurance Number may also be used as an identification number where required in the administration of benefits.

4. Date of birth: Year 1957 Month Jan Day 14

Employer Information

1. Your Employer's Name: Nishnawbe-Aski Legal Services Corporation

Address: Street & Number 86 S. Cumberland Street

City Thunder Bay Province ON Postal Code P7B 2V3

Telephone Number: (807) 622-1413

* 2. Group Plan Number 106790

Plan number must be completed. If unknown, please check with your employer.

Claim Information

1. What is the nature of your condition? Infection on Knee replacement
2. If disability is due to an accident, give date accident occurred: Year ____ Month ____ Day ____

   Where and how did it occur? ____

   Was the accident work-related? ☐ Yes ☐ No
3. From what date has your disability continuously prevented you from performing your regular work?

   Year 2017 Month Nov Day 8
4. Have you performed any **other** work since that date? ☐ Yes ☒ No

   If yes, describe ____
5. Are you able to do any other work? ☐ Yes ☒ No

   If yes, describe ____
6. Please provide the name(s) and telephone number(s) of your attending physician(s).

* ____

Financial

1. Have you applied for, or are you receiving the following:

	I have Applied Yes	I have Applied No	I am Receiving Yes	I am Receiving No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☒	☐	☐	$
Workers' Compensation Board Benefits (or similar plan)	☐	☒	☐	☐	$
Employment Insurance Benefits	☐	☒	☐	☐	$
Automobile Insurance Benefits	☐	☒	☐	☐	$
Any other Disability Benefits	☐	☒	☐	☐	$
Employer Sponsored Retirement / Pension Plan Income	☐	☒	☐	☐	$
Self Employment Income or any other Employment Income			☐	☒	$
Any other income	☐	☐	☒	☐	$ 78300

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

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

2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes ________________ Plan Number ☒ No

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

DIRECT DEPOSIT AUTHORIZATION

Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account.**

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.

⑈000⑈ ⑆01234⑉001 1234 56⑉7⑈

TRANSIT# INSTITUTION# ACCOUNT#

TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
24037	001	3994-490

Bank of Montreal

NAME OF BANK, TRUST CO, CREDIT UNION, ETC.

November 30, 2017

DATE

Keith William McKay

SIGNATURE OF EMPLOYEE

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THE
Great-West Life
ASSURANCE COMPANY

Application for Disability Income Benefits
Employee's Authorization Request

Protecting Your Personal Information
At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

106790	137
Group Plan Number	GWL Employee Identification Number
William J. McKay	Keith William McKay
Print Employee Name	Employee Signature
November 30, 2017	(807) 212-6283
Date	Telephone Number

M5454-9/15

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CLHIA ACCAP

The patient is responsible for any fees related to the completion of this form.

The Great-West Life Assurance Company

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial): McKAY, KEITH WILLIAM

☒ Male ☐ Female

Home Phone # (+ Area Code):

Cell Phone # (+ Area Code): 807 412-6283

Address (Street, City, Province, Postal Code): Kasabonika

Employer's Name: Nishnawbe-Aski Legal Services Corp.

Group Plan Number: 106790

GWL Employee Identification Number: 137

Height:

Weight:

Date of Birth (dd/mm/yyyy): 14/01/57

Last Date Worked (dd/mm/yyyy): 07/11/2017

Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy):

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature

Date of Consent (dd/mm/yyyy)

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: Right knee septic arthritis

Secondary and/or Complications: Total right knee replacement, repeat

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

Occupational Illness/Injury Yes ☐ No ☒

If yes, date of event: (dd/mm/yyyy)

Auto Accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy)

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) Nov 11 2017

First date of work absence due to condition: (dd/mm/yyyy) Nov 8 2017

Hospitalization

Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): Nov 8 2017

Date of discharge (dd/mm/yyyy): Expected Dec 1 2017

Institution Name: Sioux Lookout Nov 8-11; Thunder Bay Regional Nov 11-23; Sioux Lookout Meno Ya Win Nov 24 - Dec 1

If surgery was performed please provide date and description of surgery:

Date (dd/mm/yyyy): Nov 11 2017

Description: synovectomy, washout & total knee arthroplasty replacement

Treatment (drug, dosage, physiotherapy, other): surgery + IV antibiotics (ertapenem + vancomycin ~~Nov 15~~ Nov 8-15 + cefazolin Nov 15-27 + penicillin G Nov 27 - Dec 25) + physiotherapy

Prognosis Please provide the prognosis for recovery: Gradual return to activities over 4-6 weeks. Full recovery with possible decreased range of motion of kn

M5454-9/15

CLHIA ACCAP

THE Great-West Life ASSURANCE COMPANY

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☒

If yes, date (dd/mm/yyyy): ______ Treatment Provider: ______

Please describe the patient's symptoms including history, severity and frequency:
Right knee pain, stiffness, leg weakness
Continuing IV antibiotics until Dec 25
outpatient physical therapy

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other three times weekly

➡ Please attach copies of all relevant:
- test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- consultation reports

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

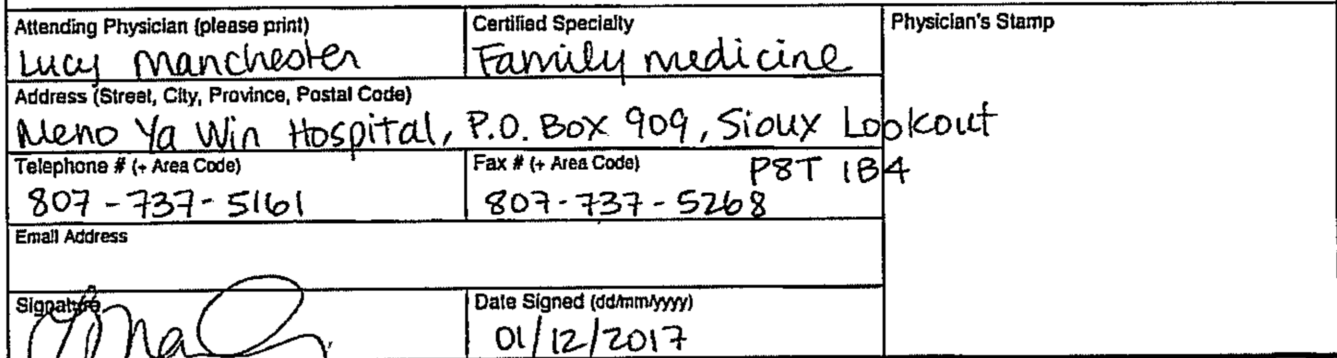
Name of Specialist: Dr Schreiber Specialty: Infectious Disease Date of Visit: NOV 07 & Dec 11 2017

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities.
Dr Droll - orthopedic surgery - Nov 11 & Dec 11 2017
Walking independently with cane, limited to 40m distance

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.
N/A

Is the patient following the recommended treatment program? Yes ☒ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)
Likely several months, minimum 4-6 weeks, before return to full activities; to be determined at patient's specialty follow-up.



Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Lucy Manchester	Family medicine	
Address (Street, City, Province, Postal Code): Meno Ya Win Hospital, P.O. Box 909, Sioux Lookout P8T 1B4		
Telephone # (+ Area Code): 807-737-5161	Fax # (+ Area Code): 807-737-5268	
Email Address:		
Signature: [signature]	Date Signed (dd/mm/yyyy): 01/12/2017	

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www.greatwestlife.com

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CONSULTATION REPORT

SL AC N

Name: MCKAY,WILLIAM JOHN
MRN: SL00011787
Account: SA070321/17
DOB: 14/01/1957
HCN: 3057748901-VK
Residence: KASABONIKA
Band #: 148
Band Name: KASABONIKA LAKE
Family Physician: AARON ROTHSTEIN MD
Admission / Service Date: 23/11/17
Address: BOX 133, KASABONIKA, ON, P0V 1Y0
Phone: 807-535-9175

DATE DICTATED: November 27, 2017

INFECTIOUS DISEASE CONSULTATION

REASON FOR CONSULTATION: Right total knee arthroplasty prosthetic joint infection, secondary to group A strep.

CURRENT ANTIMICROBIALS:
Cefazolin 2g IV q.8 since November 15, 2017.
Previously ertapenem and vancomycin since November 8, 2017.

CLINICAL COURSE: Sometime in the early fall, Mr. McKay, a 60-year-old man sustained a scratch while walking around in the bushes. He did apply some Polysporin, but noticed increasing redness spreading up his legs. He eventually collapsed one day onto his right leg being unable to weightbear due to pain. I am not clear whether he was systemically unwell at the time, but eventually was medevac'd out to Sioux Lookout Meno Ya Win Hospital for assessment. There, he was noted to have a violaceous rash on the leg which was also quite tender as well as a swollen knee. Joint aspirate was performed which led to the diagnosis of group A strep, wound culture prior to that had also grown group A strep. He was empirically treated with vancomycin and ertapenem, then transferred down to Thunder Bay Regional Health Sciences Centre for operative management of his prosthetic joint. On November 11, 2017, he underwent an irrigation and debridement, right knee synovectomy and liner exchange of his right TKA. He was subsequently switched to cefazolin.

He has a PICC line in. He is doing quite well, noticing decreasing pain and is able to weightbear and participate in physiotherapy. He is quite keen on returning home to his community within the next 2 weeks well before the likely suggested time course for his antibiotics.

He denies any adverse effects.

PAST MEDICAL HISTORY: Type 2 diabetes.

ALLERGIES: ACETAMINOPHEN, PRODUCING RASH.

EXAMINATION: He is alert and oriented. There are some limitations to extension of his right knee which is still somewhat swollen. He has a dried blistering rash on the anterior surface of his leg with some old blisters that appear to have been hemorrhagic on the dorsum his foot and

THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

For GWL Head Office Use Only

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Plan number: 106790 Division number: 1 Benefit class: 2

Plan sponsor: Nishnawbe-Aski Legal Services

Plan member ID: ______ Cost centre (if applicable): ______

Eligible date of employment: Month 07 Day 04 Year 2011

Occupation: Community Intervention Worker Earnings: $ 18,000.00 per ☒ year ○ month ○ week ○ hour

Plan member province of residence: ON Plan member province of employment: ON

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Plan member name (print): McKay (last name) Keith (first name) William (middle initial)

Gender: ☒ Male ○ Female Date of birth: Month 01 Day 14 Year 1957

Plan member mailing address:

Street address: KASABONIKA LAKE, ONTARIO.

City: KASABONIKA Province: ONTARIO Postal code: P0V-1Y0

Do you have a spouse (married, common-law or civil union spouse)? ☒ Yes ○ No

Do you have dependant children, including full time students or disabled adults? ○ Yes ☒ No

How many dependants in total, including spouse? ______

3. Refusal of Benefits

This section is to be completed by the plan member.

Cross outs and/or corrections in this section must be initialed.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for ○ myself and my dependants ○ my dependants only

Dentalcare for ○ myself and my dependants ○ my dependants only

Spousal insurer's name: ______ Plan number: ______

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original of this form will be required for a life claim.

Crossed out or corrected beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's name(s) (last name / first name / middle initial)	Percent allocated	Relationship to plan member
McKay / Joyce / A	100%	

To be divided as follows: ☒ As per the percentages indicated above, or ○ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation:

○ **Revocable.** I may change this beneficiary designation at any time.

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

CONTINUE ON REVERSE SIDE

M5108(GN)-4/07

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To be completed by the plan administrator

Plan number: ______ Plan member name: ______ Plan member ID: ______

5. Dependant Information

This section is to be completed by the plan member.
Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependants in section 3.
If there are more than four dependants, please attach a separate list. Please print clearly in INK.

Spouse Information

McKay Joyce A.
last name / first name / middle initial

Date of birth (month/day/year): 04/23/53

Gender: Male ○ Female ○

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
○	○	○	○	○	○	○	○	○	○	○	○

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependant Information

last name	first name	middle initial	Date of birth month/day/year	Gender Male	Gender Female	Full time student Yes	Disabled dependant Yes
McKay	Jamie		02/26/09	●	○	○	○
Shewaybick	Cole		09/09/04	●	○	○	○
				○	○	○	○
				○	○	○	○

6. Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to determine your eligibility for coverage, and to administer the plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship.

7. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: Keith W. McKay Date: July 26/2011