Nishnawbe-Aski Legal Services
Corporation

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FAX COVER

Date: Oct 28 2015
To: ~~Paul~~ Jeff Robert
Fax: 807-737-2093
From: ~~JEFF ROBERT~~ Don Saimawp
RE: Form to be Fwd.

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

Head Office:

100 Anemki Drive,
Suite 106
Fort William First Nation
Thunder Bay, Ontario
P7J 1J4

Message:

To Be Fwd to Don Saimawp

We are transmitting the following 9 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: 807 706 70 74

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622 3024

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.

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 Don Initial ______ Last Sainnawap

   Address: Street & Number 205-11 Millar Cresent

   PO Box 1531

   City Sioux Lookout Province Ont Postal Code P8T1C3

   Telephone: Home (807) ______ Work (807) 737.5201

   Cell (807) 738.4373

2. Your GWL Employee Identification Number ______

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

3. Social Insurance Number 454636606

   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 1956 Month 09 Day 20

Employer Information

1. Your Employer's Name: Nishawbe-Aski Legal Service Corp

   Address: Street & Number 86 S. Cumberland St

   City Thunder Bay Province Ont Postal Code P7B2V3

   Telephone Number: (807) 622 1413

2. Group Plan Number ______

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

Claim Information

1. What is the nature of your condition? Acute grief
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 ______ Month ______ Day ______

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).

   Dr Mike Kirlew. Menoyawin Hospital 807. 737. 3030

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	☐	☒	☐	☒	$

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⑉567 1234 56⑈78⑈

TRANSIT# INSTITUTION# ACCOUNT#

TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)
_ _ _ _ _	_ _ _	0835536

068 00387010

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

Oct 30/15

DATE

[signature]

SIGNATURE OF EMPLOYEE

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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.

Group Plan Number:

GWL Employee Identification Number:

Print Employee Name: Don Sainnawap

Employee Signature: Don Sainnawap

Date: Oct 30/15

Telephone Number: 807 738 4373

If you would like Great-West Life to email you, please fill in your email address below. By giving us your email address, you are allowing Great-West Life to communicate with you at this address, and acknowledge that the security of email communication cannot be guaranteed.

Email Address: dsainnawap@nanlegal.on.ca

M5454-12/14

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

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)	☒ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Don Sainnawap		807.737.3592	807.738.4373

Address (Street, City, Province, Postal Code): P.O. Box 1531, Sioux Lookout, Ont P8T 1C3

Employer's Name	Group Plan Number	GWL Employee Identification Number
Nishnawbe-Aski Legal Services		

Height 5'7	Weight 176	Date of Birth (dd/mm/yyyy) Sept 20/56

Last Date Worked (dd/mm/yyyy)	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.

Don Sainnawap — Plan Member/Employee Signature

Oct 30/15 — 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: ACUTE GRIEF REACTION

Secondary and/or Complications: MAJOR DEPRESSION

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

Occupational Illness/Injury Yes ☐ No ☒	Auto Accident Yes ☐ No ☒
If yes, date of event: (dd/mm/yyyy)	If yes, date of event: (dd/mm/yyyy)

Date of first visit to you pertaining to this condition: (dd/mm/yyyy)	First date of work absence due to condition: (dd/mm/yyyy)

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): N/A Date of discharge (dd/mm/yyyy): Institution Name:

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

Date (dd/mm/yyyy): N/A Description:

Treatment (drug, dosage, physiotherapy, other): PSYCHOTHERAPY

Prognosis Please provide the prognosis for recovery: GOOD PROGNOSIS FOR RECOVERY

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:

[illegible] depression symptoms.

[illegible]

Frequency of Visits: ☒ Weekly ☐ Monthly ☐ Other ______

➡ 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: ______ Specialty: ______ Date of Visit: ______

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities.

Cognitive abilities [illegible]

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)

Condition should improve [illegible] months

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
M. [illegible]	Family Medicine	
Address (Street, City, Province, Postal Code) [illegible]		
Telephone # (+ Area Code) 807-737-[illegible]	Fax # (+ Area Code)	
Signature [signature]	Date Signed (dd/mm/yyyy)	

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