

Waiver of Life Insurance Premiums Employee Statement Guide

How to apply for waiver of life insurance premiums

Notify Canada Life of your disability as soon as possible:

- Complete the attached Employee statement and consent form
- Mail, fax or email your completed Employee statement, consent form and any other information you'd like us to have, to the Canada Life Disability Management Services Office (DMSO). Fax and email information is available on our website at canadalife.com, from your employer, or you can contact us at **1-855-755-6729** for assistance.

Your signature on the claim form and the consent is needed to make sure you understand the purpose and benefits of your claim and provides Canada Life permission to get additional information from:

- Your employer
- Other insurers
- Your doctor and other healthcare providers

Send these forms to Canada Life 8 weeks before the end of the waiting period to make sure your claim is handled as soon as possible.

Why we need medical information

Medical information is needed to understand how your condition(s) prevent you from working. Please have your healthcare provider complete the **Attending Physician's Statement**. The completed form can be sent to us directly.

Information from your employer

Your employer will complete an Employer statement confirming your employment details and job information to help us assess and administer your disability claim. Your employer will send the completed form to Canada Life directly.

Your responsibilities

Remember to:

- Keep in touch with your employer, co-workers and Canada Life during your recovery.
- Set goals to help work towards recovery.
- Stay active. Look after yourself.

Talk to your healthcare providers about return-to-work planning. Recovering while at work can be a healthy option. Canada Life supports early return to work opportunities and will work with you to help plan for a healthy future.

To begin your claim submission:

- Complete the Employee Statement and consent form
- Have your healthcare provider complete a physician's statement
- Submit forms within 8 weeks of the end of waiting period. Your claim may be declined if not submitted within the notice period in your group contract.

NOTE: Canada Life takes the submission of fraudulent claims seriously and will verify the accuracy of the information given in support of your claim.

I certify the information given on this claim form is true, correct, and complete to the best of my knowledge.

Your employer's name: _____

Your group plan number: _____ Your Canada Life ID number: _____

Your personal information

First name: _____ Middle initial: _____ Last name: _____

Gender: Male Female Undisclosed Other

Date of birth: _____

Home address: _____

City / Town: _____ Province / Territory: _____ Postal Code: _____

Work location (City / Town and Province / Territory): _____

Home phone : _____ Confidential

Cell phone: _____ Confidential

Email address: _____

Check the confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim.

What level of education have you completed High School No Yes Grade Completed _____

Business or Trade School No Yes College No Yes University No Yes Years completed _____

Major/Minor _____ Degree/Diploma/Certificate _____

Your employment information

What was your last day of work (mm/dd/yyyy): _____

What was the first day you were unable to work (mm/dd/yyyy): _____

Have you returned to work? No Yes **If yes**, when did you return? (mm/dd/yy): _____

I returned to (select all that apply): Regular duties and hours Modified duties Modified hours

If no, when do you expect to return? (mm/dd/yyyy): _____

OR Unknown **OR** I'm not planning to return

What aspects of your job are you able to do?

During your absence, have you performed any **other** work? No Yes. If yes, describe:

Your medical information

What is/was the medical condition causing your absence from work?

Is your condition work related? No Yes. If yes, Worker's Compensation case number: _____

Is your condition the result of an accident? No Yes **If yes:**

When and where did the accident occur? (mm/dd/yyyy): _____

Provide details of the accident:

Was the accident motor vehicle related? No Yes. **If yes**, in what province did your accident occur? _____

Your treatment information

Were you admitted to a hospital? No Yes Hospital name: _____

Date admitted (mm/dd/yyyy): _____ Date discharged (mm/dd/yyyy): _____ **OR** Still hospitalized

Have you had surgery since being off work, or is surgery planned? No Yes

Date of surgery (mm/dd/yyyy): _____ Type of surgery: _____

Other treatment (crutches, physiotherapy, medication, etc.):

Please provide the following information for your primary healthcare provider:

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Do you have other healthcare providers related to this claim? No Yes **If yes**, provide details.

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Provider's name: _____ Specialty: _____

Address: _____

Phone number: _____ When did you begin seeing this provider? (mm/yyyy) _____

Please attach a separate sheet if additional space is required

Your financial information

Have you applied for, or are you receiving any income either as a result of your disability or otherwise? (check no or yes):

	Applied for	Receiving	Gross Amount	Start Date
• Canada Pension Plan/Quebec Pension Plan:				
o Disability Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Dependent Benefits due to your disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Retirement Pension	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
o Other (please specify) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
• Worker's Compensation Board (or similar benefits)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
• Other income (such as Auto Insurance benefits, Employment Insurance, Pension Plan)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Please specify _____				
• Self-employment or other employment income.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____


Other coverage

Other than the benefits you are applying for here, please indicate if you have other insurance coverage with Canada Life or another insurance carrier:

	Plan/Policy #	Insurance Company
<input type="checkbox"/> Group Disability Insurance:	_____	_____
<input type="checkbox"/> Individual Disability Insurance:	_____	_____
<input type="checkbox"/> Individual Life Insurance	_____	_____
<input type="checkbox"/> Creditor / Loan Insurance	_____	_____
<input type="checkbox"/> Critical Illness Insurance	_____	_____

Declaration

By signing this form, I declare the information I've entered is accurate. I understand and agree to the terms in the Income declaration and reimbursement agreement section. I also acknowledge that I need to print, sign, and submit my Consent form to Canada Life.

Date of birth (yyyy/mm/dd)	Telephone Number	Date signed (yyyy/mm/dd)
Your name (please print)		Signature 
Enter your email address if you would like Canada Life to communicate with you by secure email.		



Protecting your personal information

At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information

Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with

We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information

We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your [online account](#) or by submitting a request through our [privacy centre](#) at canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit canadalife.com/privacy.



Your consent



Sharing your personal information

Before we can process your claim for benefits, you must read this agreement and sign in the signature box below.

We collect, use and disclose your personal information to:

- Investigate and assess your claim(s) under the group benefits plan
- Administer your claim and the group benefits plan
- Work out a rehabilitation plan to get you back to work
- Audit the assessment of the claim
- Manage internal data for analytics purposes


We may also use your social insurance number for income tax reporting if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Insurance and reinsurance companies
- Administrators of the plan, of government benefits and of other benefit programs
- Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
- Your employer's occupational health services
- Your union representative
- Service providers and other organizations working with us, or on behalf of the other parties mentioned above. We may use service providers outside Canada.
- An auditor authorized by us, your employer, plan sponsor or their agent

Privacy consent, authorization and declaration

- ✓ I have read, understand and agree with the contents of this form and authorize Canada Life to collect and exchange my personal information.
- ✓ I understand that my personal information will be collected, used and shared as set out above.
- ✓ Except for audit purposes, my authorization is valid for the duration of my claim or until I cancel it in writing.
- ✓ All statements I have made about my claim are true and complete.
- ✓ A photocopy or electronic copy of this authorization is as valid as the original.

Date of birth (yyyy/mm/dd)	Telephone Number	Date signed (yyyy/mm/dd)
Your name (please print)		Signature 
Enter your email address if you would like Canada Life to communicate with you by secure email.		