

# **Long Term Disability Income Continuance Plan**

**Government of the  
Province of Alberta**

**GROUP PLAN 50007**

**Government  
of Alberta ■**

**Employee's Statement**

# **How to Submit a Claim For Long Term Disability Income Benefits**

This guide explains how to apply for Long Term Disability Income Continuance (LTD) Plan benefits and some important information about the claims process.

The Adjudicator, Great-West Life Disability Management Services Office in Edmonton, will receive and assess your claim. The Adjudicator is an independent third party who determines if you qualify for LTD benefits, how long you can receive benefits, and when you are fit to return to work. Please note that LTD benefits will not be paid for any period during which you are not under the continuous care of or not following the treatment prescribed by a physician.

Depending on the nature and severity of your condition, Great-West Life may require you to be under the care of a specialist, or undergo an Independent Medical Exam.

If substance abuse, including alcoholism and drug addiction, contributes to your disability, your treatment program must include participation in a recognized substance withdrawal program.

To begin the claim submission process, you need to review and sign the “Employee’s Responsibilities” section, complete the “Notice of Claim” and “Authorizations and Declarations” forms, and arrange to have your doctor complete the “Attending Physician’s Initial Statement.” **This information is included in this guide and should be completed and submitted as quickly as possible and sent directly to Great-West Life at the following address:**

**Great-West Life Assurance Company  
#202, Cecil Tower  
10110 - 104 Street  
Edmonton, Alberta T5J 4R5  
  
Telephone: 780-917-7776 or 1-888-328-8688  
Fax: 780-425-0744**

## **Notice of Claim Form**

The Notice of Claim gives Great-West Life basic information about you, your job and the nature of your disability. Please complete all questions on this form and return the form immediately to Great-West Life.

## **Authorizations and Declarations Form**

The Authorizations and Declarations form allows Great-West Life to obtain more detailed information to establish whether or not you are entitled to benefits and to exchange information when relevant and necessary for the purpose of managing the claim. You must sign the Authorizations and Declarations form contained in this guide before assessment can begin. Please submit the form directly to Great-West Life.

## **Attending Physician’s Statement**

Ask your doctor to complete this form. It covers general information on your condition. To expedite the assessment process, please ensure that your doctor includes copies of any test results, copies of clinical notes and specialist consultation reports related to your current condition. You or your doctor should submit the Physician’s Statement directly to Great-West Life.

**All forms should be completed and submitted immediately.**

# What You Should Know About the Claim Process

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## Employer's Statement

Your Ministry will also submit an "Employer's Statement" directly to Great-West Life. This statement will confirm your effective date of coverage, job information, monthly earnings, and other information that Great-West Life needs to assess your claim.

## Claim Interview

A Great-West Life Case Manager will be assigned to your disability claim. They will contact you to obtain information about your job, your education and employment history, and your medical history as it relates to your current condition. Great-West Life will also require information about certain other sources of income that could affect the amount of your benefit.

The interview questions may seem very detailed. However, Long Term Disability benefits are complex, and a great deal of information is necessary to ensure that Great-West Life assesses your claim correctly. Please be patient and answer all questions as thoroughly as possible.

If an interview is not possible because of medical or language problems, Great-West Life will make other arrangements.

## Medical Information

**You are responsible** for providing medical proof that you are entitled to benefits, and this includes responsibility for providing medical reports. Your doctor may or may not request a fee for completing claim reports. Any fees are your responsibility.

Whenever Great-West Life requests information directly from your physician, they will offer a correspondence fee as a matter of courtesy. However, Great-West Life will ask your doctor to bill you directly for any additional fees, or for fees relating to reports that you may request.

**All medical information is handled confidentially.**

## Claim Assessment

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Great-West Life will assess your claim as soon as they receive the completed forms from you, your doctor and your employer.

Under the LTD Plan Regulation, disability means a medical condition that causes an employee to be unable to:

- (i) *perform any combination of duties which, prior to the commencement of illness or injury, regularly took at least 60 percent of the employee's time at work to complete, or*
- (ii) *be gainfully employed.*

"Gainfully employed" means *employment that an employee is medically fit to perform, for which the employee has at least the minimum qualifications and that provides a salary of at least 60 percent of the employee's pre-disability salary.*

## **Benefit Approval**

Great-West Life and the LTD Liaison Officer will notify you if Great-West Life accepts your claim in accordance with the terms of the LTD Plan Regulation. At that time, the LTD Liaison Officer will also provide other pertinent information regarding your claim. Great-West Life does not make any benefit payments; these are processed through Government of Alberta Pay and Benefits. Great-West Life will continue to monitor your claim on an ongoing basis and will request regular updates.

## **Benefit Denial**

If Great-West Life does not approve benefits, they will send a letter directly to you explaining the reasons for the denial. The LTD Liaison Officer will also send you a letter advising you of the declination of benefits and your right to request a review (appeal) of this decision.

## **Rehabilitation**

While you are in receipt of LTD benefits, Great-West Life may request you to participate in a Rehabilitation Program for the purpose of assisting you to return to work.

Your return may be a gradual re-entry into work or a more comprehensive program requiring the professional expertise of one of Great-West Life's Rehabilitation Consultants.

You must participate or cooperate in an approved Rehabilitation Program, if requested, or Great-West Life may terminate your benefits.

Please retain pages 1-3 for future reference. Complete and return pages 4-8 to Great-West Life. Pages 9 and 10 (Attending Physician's Initial Statement) are to be completed by your doctor and returned to Great-West Life. Further information on the Long Term Disability Income Continuance Plan is available at <http://www.chr.alberta.ca/ltd>, or you can contact your supervisor or the [LTD Liaison Officer](#).

## Employee's Responsibilities

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Once Great-West Life approves your claim, you are responsible to:

- Be available for a work assessment or a rehabilitation program or a medical examination, if required.
- Notify Great-West Life and your Ministry of your whereabouts if residing away from your normal place of residence.
- Provide updated medical information as required.
- Follow treatment as prescribed by licensed physicians.
- Apply for CPP Disability benefits within 12 months of being placed on LTD.
- Report all income from any employment, self-employment or any other sources.
- Seek alternative employment where necessary.
- Participate in a Rehabilitation Program, if requested.

Your failure to satisfy the above may jeopardize your continued receipt of benefits.

I have read and understood the above requirements of the LTD Plan.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

# NOTICE OF CLAIM

## IDENTIFICATION

1.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Name	First	Initial	Last		
	Number & Street				
Address	P.O. Box				
	City	Province	Postal Code		
Home Telephone Number	( )	Cell Phone Number	( )		
Employing Ministry					
2. Date of Birth	Year	Month	Day		

## CLAIM INFORMATION

1. What is the primary condition preventing you from working?	
2. Is there a secondary condition?	
3. Have you had this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Name of Doctor who first diagnosed or treated you for this condition	
From what date have you been unable to work because of this condition?	

Your Great-West Life Case Manager will be contacting you for a telephone interview. What is the best time to call for claim interview?	
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# MEDICAL TREATMENT

**1. Full name and address of the physician currently supervising your treatment:**

Name		Address	
( )	( )	( )	( )
Phone Number		Fax Number	
Dates: From		To	

**2. Full name and address of other physicians/caregivers who have treated you for this condition:**

Name		Address	
( )	( )	( )	( )
Phone Number		Fax Number	
Dates: From		To	

Name		Address	
( )	( )	( )	( )
Phone Number		Fax Number	
Dates: From		To	

**3. Were you hospitalized?  Yes  No If yes, complete the following:**

Hospital Name		Address	
( )	( )	( )	( )
Phone Number		Fax Number	
Dates: From		To	

Hospital Name		Address	
( )	( )	( )	( )
Phone Number		Fax Number	
Dates: From		To	

# FINANCIAL

Have you applied for, or are you receiving for your present medical condition, any (or all) of the following:

	Applied	Receiving	Amount
Canada Pension Plan or Quebec Pension Plan Disability benefits	_____	_____	_____ per month
Workers' Compensation	_____	_____	_____ per week / month
Auto Insurance Loss of Income Benefits	_____	_____	_____ per week / month
Other (please specify)	_____	_____	_____ per week / month

# INCOME DECLARATION

1. I agree to notify my Employer of any reportable income, as defined below, that I receive or for which I become eligible during the period of my disability claim.
2. I agree to provide this notice within 30 days after income is first received or awarded.
3. I recognize and accept my obligation to repay any overpaid benefits according to the terms of the Government of Alberta Long Term Disability Income Continuance Plan as a result of my entitlement to other income. I agree to repay such amounts after I have been notified of an overpayment.

Personal income is reportable if it might affect, or be affected by, benefits under this plan. It includes:

- Workers' Compensation Benefits
- Canada Pension Plan (Contributor's only) or Quebec Pension Plan Disability Benefits
- Employment or Self-Employment Income
- Auto Insurance Loss of Income Benefits

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

# AUTHORIZATIONS AND DECLARATIONS

## Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. We limit access to information in your files 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. We use the information to investigate and assess your claim and to administer the group benefit plan.

**To give Great-West Life the right to investigate your claim, you must sign the following authorizations:**

### Authorizations and Declarations

I authorize

- Great-West Life, any healthcare or rehabilitation 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 my information, when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan or performing independent assessments;
- Great-West Life to exchange my information with my employer, plan sponsor, or plan administrator when relevant for the purpose of discussing rehabilitation and return-to-work planning;
- Great-West Life to release my information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims.

Except for audit purposes, this authorization 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 Employee's statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of this claim.

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Print Name

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Signature

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Date

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Telephone Number

# ATTENDING PHYSICIAN'S INITIAL STATEMENT – LONG TERM DISABILITY

(PAGE 1)

<b>Name of Patient</b> _____								
<b>Name of Employer</b>	<b>Government of Alberta</b>	<b>Group Policy 50007</b>						
<b>1. HISTORY</b>								
a) Date symptoms first appeared or accident happened	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">Year</td> <td style="width: 20px; text-align: center;">Month</td> <td style="width: 20px; text-align: center;">Day</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	Year	Month	Day				
Year	Month	Day						
b) Has patient ever had the same or similar condition in the past? If yes, please specify diagnosis and dates of treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No							
c) Did this condition arise as a result of this patient's employment? _____								
d) Current Height _____ Current Weight _____								
<b>2. DIAGNOSIS</b> (including any complications)								
a) Primary Diagnosis _____								
b) Secondary Diagnosis _____								
c) Subjective Symptoms (including severity) _____								
d) Details of objective medical findings including severity. _____								
e) Mental Disabilities: How does the patient's mental impairments affect his/her ability to work? (Please include GAF if available from specialist consultation.) _____								
<b>Include copies of clinical notes, test results and copies of consultation reports.</b>								
<b>3. PHYSICAL ABILITIES</b> (please specify current level of physical ability)								
<input type="checkbox"/> <u>Sedentary Duties</u> : requires mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.								
<input type="checkbox"/> <u>Light Duties</u> : requires frequent handling of loads of up to 5 kg, sometimes up to 11 kg. May require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.								
<input type="checkbox"/> <u>Medium Duties</u> : requires frequent handling of loads of up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing or pulling may also be required.								
<input type="checkbox"/> <u>Heavy Duties</u> : requires frequent handling of loads up to 23 kg, sometimes up to 45 kg.								
List physical restrictions and tolerances _____								
<b>4. TREATMENT</b>								
a) Date of first visit	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">Year</td> <td style="width: 20px; text-align: center;">Month</td> <td style="width: 20px; text-align: center;">Day</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	Year	Month	Day				Date of latest visit
Year	Month	Day						
b) Frequency of visits	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other							
If other, please specify _____								
c) What is the nature and frequency of current treatment (including medications and dosages; type and frequency of therapy; surgery performed or contemplated?) _____								
d) Please provide the names of other treatment providers who have been/will be involved in assessing the medical problem. <b>(Please include copies of their consultation reports.)</b> _____								

**ATTENDING PHYSICIAN'S INITIAL STATEMENT – LONG TERM DISABILITY**  
(PAGE 2)

<b>5.</b>	<b>CURRENT MEDICAL STATUS</b>
a)	Has the patient's condition improved since the first visit? If yes, to what degree? _____ _____
b)	If the patient is not ready to return to work, what are the future treatment plans to aid in the recovery? _____ _____
<b>6.</b>	<b>REHABILITATION</b>
a)	When can the patient return to work, full-time or part-time? _____  If the patient has not returned to work, is the patient a suitable candidate for a return to work program either in his/her own occupation or alternate work? _____ _____
b)	Are you aware of any workplace issues that may be prolonging the patient's recovery? _____ _____
<b>7.</b>	<b>ADDITIONAL INFORMATION</b>
	We would appreciate any additional comments you would care to make that would help us to better understand your patient and the problems they face with their present condition. _____ _____ _____

<b>Name of Physician</b> (please print) _____		
<b>Specialty</b> _____	<b>Telephone #</b>   (    )	<b>Fax #</b>   (    )
Address (number, street, city, province and postal code)   _____   _____		
_____	Date	Physician's Signature

**Note to Physician:**  
The information on this form should be compiled from your existing medical records. A new examination is not required. By providing complete details in this format, it will hopefully reduce your administrative workload. To avoid delays in the assessment of your patient's claim, please attach copies of the clinical notes, consultation reports and test results. If this information is attached, we are prepared to provide a courtesy fee of \$40.00 to cover your administrative cost. The patient is responsible for any additional fees in excess of \$40.00 for the completion of this form. Please mail or fax the completed form and invoice, as indicated below or, at your discretion, return it to your patient.