

Important:

The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed in its entirety and submitted to Great-West Life within 5 days of the onset of the disability.** Great-West's Privacy Guidelines and applicable law allow claimants 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 claimant.

Ensure all sections and both pages are completed as lack of information will cause delays in claim assessment.

A. EMPLOYER IDENTIFICATION

| | | | |
|--------------------------|-------------|---------------------------------|-----------------------|
| Name | Plan Number | Division Number (if applicable) | Class (if applicable) |
| Address: Street & Number | P.O. Box | City | Province |
| | | | Postal code |

B. EMPLOYEE IDENTIFICATION

| | | | | | |
|--------------------------|----------|------|----------------------|-------------------------|---------------|
| Name: First | Initial | Last | Employee I.D. Number | Social Insurance Number | Date of Birth |
| Address: Street & Number | P.O. Box | City | Province | Postal Code | |
| Telephone Number | | | Fax Number | | |

C. EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY) _____ Date last worked (MM/DD/YY) _____ Number of hours _____

Reason for absence Medical Leave of Absence Strike Dismissed Work related accident or sickness
 Quit Retired Other Temporary Lay-off Paid Vacation

Is the employee: Full time: Number of hours worked per week _____ Part time: Number of hours worked per week _____

Is the employee: Permanent Temporary Seasonal Contract

Is the employee Hourly Salaried Commissioned

Please attach copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

| | | |
|---|---|---|
| Has employee returned to work? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No | If no, is a return to work date known? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No | Has employment terminated? <input type="checkbox"/> Yes _____ MM/DD/YY <input type="checkbox"/> No |
|---|---|---|

D. INSURANCE INFORMATION

| | |
|--|--|
| Date employee became insured under the Short Term Disability Plan. (MM/DD/YY) _____ | When did the employee apply for insurance? (MM/DD/YY) _____ |
| Is the employee covered for Guaranteed Standard Issue Program Insurance with Great-West Life? <input type="checkbox"/> Yes _____ Policy Number <input type="checkbox"/> No | |

E. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

| | | | | |
|--|--|--|--|---|
| Employee's Gross Weekly Earnings: \$ _____ per week | Average monthly commissions earned in the 24 months ending on the last day worked: | Employee benefit amount (according to your records): | TD-1 Federal personal tax credits (Dollar amount): | For Quebec residents, tax deductions according to the latest TP-1015.3: |
|--|--|--|--|---|

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? Yes No
 If yes, percentage of employment income that is tax exempt: _____ %

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ **Date:** _____

Name (please print): _____ **Title:** _____

Phone: _____ **Fax:** _____

F. JOB INFORMATION

Employee's job title as of last day worked

How long has the employee worked in this position?

Years

Months

COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER. If you have a prepared job description, please include it with this submission.

What are the duties in this job, and what percentage of time does each take per week?

Duties

Percentage of time per week

| Duties | Percentage of time per week |
|--------|-----------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

To ensure proper management of this claim, more detailed job information may be requested at a later date.

When did the employee's disability first appear to affect his/her work? (MM/DD/YY)

In what ways did performance on the job change as a result of the disability?

Were any changes made in the employee's job duties as a result of the disability? Yes No

If yes, please explain what the changes were and when they were made:

If the employee could return to part-time or less demanding work, would such work be available? Yes No

If no, please explain.

ADDITIONAL INFORMATION

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

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Supervisor or Authorized Signature: _____ Date: _____

Name (please print): _____ Title: _____

Phone: _____ Fax: _____