Chambers of Commerce Group Insurance Plan®

Long Term Disability Claim

Any absence from work on either a short or long term basis as a result of illness or accident can be a stressful period, particularly if your income is affected. In order to facilitate the filing of your claim for Long Term Disability Benefits, Business Overhead Expense Benefits and Waiver of Premium Benefits, and to minimize the delay in releasing the initial payment, we have prepared this package to assist you. For your convenience a checklist is included below. If any questions arise as you prepare or secure the requested information, please call us on our toll-free line, 1-800-665-3365 between 8 a.m. and 5 p.m. CST, Monday through Friday, to speak with a Disability Customer Service Representative. Please note that on approval all benefits are paid monthly in arrears.

All forms must be as complete as possible and **ALL REQUIRED INFORMATION MUST BE SUBMITTED BEFORE PROCESSING OF THE APPLICATION CAN COMMENCE**. The decision rendered will be based on the information provided. Regrettably, incomplete forms or insufficient documentation will compromise our ability to achieve a timely decision on your claim. Should this happen you will be advised in writing of the status of your claim.

When complete, this claim may be:

- faxed to 1-800-457-8410,
- emailed to chdisability@johnstongroup.ca, or
- mailed to
  Chambers of Commerce Group Insurance Plan
  1051 King Edward Street, Winnipeg, MB R3H 0R4
  Attn: Disability Claims Department

FINANCIAL EVIDENCE

Earned Income is the income earned for services performed by the insured. Please include the financial evidence, as outlined, with your claim.

EMPLOYEES

Employee Income may be in the form of salaries and wages, bonuses, commissions, fees and honorariums. Please attach copies of your T4 slips for the past two years.

Income as reported to Canada Revenue Agency on your T1 Income Tax returns will be used to calculate your Earned Income and your benefits payable.

OWNERS / SELF-EMPLOYED INDIVIDUALS

Income may be in the form of salaries and wages, bonuses, company dividends (average over the last two years from T5), commissions, or the net income from the operation of a self-employed business. Earned Income does not include interest, rental income or income from capital gains, royalties, pensions, annuities, deferred compensation or any other income that does not depend upon the ability of the insured to perform services or any occupation.

Net Income is the gross income of the business, less any business expenses that can be claimed for income tax purposes, except income taxes payable on such income. **Please attach copies of pages 1 and 2 of your tax returns, along with tax schedules detailing income reported on lines 135 to 143, for the past two years.**

Income as reported to Canada Revenue Agency on your T1 Income Tax returns will be used to calculate your Earned Income and your benefits payable.

CHECKLIST FOR SUBMITTING A DISABILITY CLAIM

Make sure you have done all of the following:

- ❑ completed the forms in ink.
- ❑ each section of the forms is completed by the appropriate person.
- ❑ signed and dated all sections of the forms.
- ❑ enclosed all the required forms for your claim including a copy of your Birth Certificate, passport or Baptismal Certificate.

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Long Term Disability Claim – Physician's / Specialist's Statement

Head Office Only: Group # _____

WHAT WE REQUEST AND WHY

Your patient is making a claim for disability benefits under a Desjardins Insurance policy, and we will be assessing eligibility for benefits based on your patient's medical condition.

As you can appreciate, the information provided by you is most important in our assessment of impairment. We are asking for your co-operation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that the information, including the medical records requested are required in the adjudication of your patient's claim and will be treated confidentially. It is imperative that you enclose copies of all test and investigation reports confirming the stated diagnosis and the extent of your patient's impairments. **We also require copies of your complete file including all consultation notes, hospital admission history and discharge summary.**

Any charge for the completion of the form, is the responsibility of the patient.

Desjardins Insurance would like to thank you for your cooperation.

1) PATIENT INFORMATION

Last Name _____ Date of Birth (DD/MM/YY) _____

First Name _____ Height (in/cm) _____

Middle Name _____ Weight (lb/kg) _____

Firm and Certificate No. _____

2) BACKGROUND

1. Date symptoms first appeared (DD/MM/YY) _____ Date of first visit for current condition (DD/MM/YY) _____

   Date your patient ceased work (DD/MM/YY) _____

2. Date of latest visit (DD/MM/YY)_____ Frequency of visits: _____

3. a) Symptoms on date work ceased _____

   _____

   b) Are there any physical findings or are you basing your opinion solely on the patient's symptoms? Please explain. _____

   _____

4. Has your patient ever had the same or a similar condition? ❑ Yes ❑ No If "Yes", please state when and describe: _____

   _____

   _____

5. Do you consider this condition to be chronic? ❑ Yes ❑ No

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2) BACKGROUND (CONTINUED)

6. Was the patient referred to you by another physician? ❑ Yes ❑ No If "Yes" please supply the following.

   Name of referring physician _____ Date referred (DD/MM/YY) _____

   Address _____

7. Is the condition related to the patient's work? ❑ Yes ❑ No If "Yes", please explain: _____

3) PHYSICIAN'S DIAGNOSIS – PSYCHIATRIC DISABILITY

If the primary or secondary diagnosis is Psychiatric please complete this section. If not, proceed to section 4.

1. Primary (including complications) _____

2. Secondary diagnoses: (including complications) _____

3. **Psychiatric questions**
   a) Diagnosis (please use DSM IV terminology and codes):

      Axis I _____

      Axis II _____

      Axis III _____

      Axis IV _____

      Axis V _____

      GAF Score _____

   b) History
      Positive family history ❑ Yes ❑ No If Yes, please explain: _____

   c) Past psychiatric history diagnosis, year, duration, etc.: _____

   d) Current illness (please list all symptoms): _____

   e) Other factors influencing illness (job, home, relationships, status of professional license, bankruptcy, etc.) _____

   f) Is there a substance abuse problem? ❑ Yes ❑ No If Yes, what is the treatment program? _____

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3) PHYSICIAN'S DIAGNOSIS – PSYCHIATRIC DISABILITY (CONTINUED)

4. Mental Impairment
   How does your patient's psychiatric disorder prevent him/her from working? Please provide specific restrictions and limitations. _____

4) PHYSICIAN'S DIAGNOSIS – PHYSICAL DISABILITIES

1. Primary (including complications) _____
2. Secondary diagnoses: (including complications) _____
3. For conditions involving the upper extremity or neck, is the patient ❑ Right Handed ❑ Left Handed
4. If the patient is/was pregnant, expected/actual date of confinement (DD/MM/YY/) _____
5. Symptoms: _____
6. Physical findings. Include tests, the dates performed, and the results (please attach copies): _____
7. If this is a cardiac condition:
   a) The patient's current functional capacity based on American Heart Association classifications:
      ❑ Class 1 – No limitations ❑ Class 2 – Slight limitation ❑ Class 3 – Marked limitation ❑ Class 4 – Severe limitation
   b) List nature and date of all cardiac investigations: _____
8. Please provide the last 3 blood pressure readings _____/_____ Date (DD/MM/YY) _____
   _____/_____ Date (DD/MM/YY) _____ _____/_____ Date (DD/MM/YY) _____

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Long Term Disability Claim – Physician's / Specialist's Statement

5) PATIENT'S TREATMENT (FOR PHYSICAL & PSYCHIATRIC DIAGNOSES, IF APPLICABLE)

1. Has the patient been hospitalized? ❑ Yes ❑ No If "Yes", please provide:

Name of Hospital	Date(s) Confined from (DD/MM/YY) to (DD/MM/YY)

2. Has the patient had surgery in relation to this condition? ❑ Yes ❑ No If "Yes"

Name of Procedure(s)	Date(s) Performed (DD/MM/YY)	Name of Surgeon

3. Medication:

Name of Medication	Dosage	Frequency	Date Prescribed (DD/MM/YY)

4. Other types of treatment given or prescribed, dates of the treatment, expected duration, etc.

Type of Treatment	Date(s)	Expected Duration	Treating Professional Facility

5. Has the patient been referred to a rehabilitation program? ❑ Yes ❑ No If Yes, please provide:

Name of program _____

Dates(s) attended (DD/MM/YY) _____ Expected Duration _____

6. Has the patient consulted with or been treated by any other health care providers? ❑ Yes ❑ No If "Yes", please provide:

Name _____ Phone (_____) _____

Address _____ Treatment dates (DD/MM/YY) _____

City _____ Province _____ Postal Code _____

Name _____ Phone (_____) _____

Address _____ Treatment dates (DD/MM/YY) _____

City _____ Province _____ Postal Code _____

7. Please comment on the response to treatment: _____

8. Is the patient following the recommended treatment plan? ❑ Yes ❑ No If "No", comment on the reason and the effect: _____

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5) PATIENT'S TREATMENT (FOR PHYSICAL & PSYCHIATRIC DIAGNOSES, IF APPLICABLE) (CONTINUED)

9. Is the treatment expected to change? ❑ Yes ❑ No If "Yes", in what way and when. _____

10. a) What are the patient's specific restrictions (what the patient CANNOT do)? _____

    b) Are these restrictions expected to be permanent? If no, provide time lines for improvement. _____

11. What do you understand your patient's occupation to be? _____

12. Has the patient had any license or certification restricted or revoked (e.g. driver's license, professional license, etc.)? ❑ Yes ❑ No
    If "Yes", the type of license (including class) or certificate:

Licence No.	Type of Licence	Date It Was Revoked (DD/MM/YY)

13. Has the patient achieved maximum medical improvement? ❑ Yes ❑ No
    If "No", do you expect improvement in the patient's medical condition? _____

14. What is your prognosis? (Details of any expected improvement or deterioration and time-frames for these.) _____

15. In your opinion, is the patient capable of handling his/her own financial affairs? ❑ Yes ❑ No If "No", since what date and why: _____

6) RETURN TO WORK PLAN

1. Are you aware of the job duties of your patient's occupation? ❑ Yes ❑ No
2. Which of the following describes the progress of the patient's condition since the patient stopped working?
   ❑ Recovered ❑ Improved ❑ Unchanged ❑ Regressed
3. What is the patient's current status?
   ❑ Ambulatory ❑ House confined ❑ Bed confined ❑ Hospital confined
4. Based on your findings can the patient return to **part-time** or **modified work**? ❑ Yes ❑ No
5. If yes, do you have specific plans for the patient? If so, please provide details (i.e. timing, tasks, etc.).

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6) RETURN TO WORK PLAN (CONTINUED)

6. Is the patient fit for **any other occupation**? ❑ Yes ❑ No If yes, please give details.

7. Please describe any factors not mentioned above that may affect this patient's ability to return to work (such as social pressure, stress in the workplace or abuse of medication, alcohol or any other substance).

7) COOPERATION & WILLINGNESS TO RETURN TO WORK

Please comment on the patient's compliance with the recommended treatment plan.

Please comment on your patient's willingness and motivation to return to work.

8) ADDITIONAL INFORMATION

1. Are you providing information to any other insurers on this patient? ❑ Yes ❑ No If "Yes", list names of companies.

2. Comments or any other information that you feel will assist us in our understanding of the patient's condition.

Signature _____ Date (DD/MM/YY/) _____

Physician's Name _____ Degree and Specialty _____

Address _____ Phone (_____) _____

City _____ Province _____ Postal Code _____ Fax No. _____

NB: To allow us to make an assessment of your patients claim, it is essential that you answer all of the questions applicable to your patient, in full. This form will provide the basis upon which a decision will be made. Regrettably, incomplete forms will compromise our ability to reach a decision. This could affect your patient's income.