HEALTHCARE BENEFIT TRUST HBT BENEFIT FROM EXPERIENCE

canada life

Healthcare Benefit Trust (HBT) Policy #51337 ☐
Joint Community Benefits Trust (JCBT) Policy #59234 ☐
Joint Facilities Benefits Trust (JFBT) Policy #59233 ☐
Joint Health Science Benefits Trust (JHSBT) Policy #59232 ☐
Community Social Services Employers' Association (CSSEA) Policy #51367 ☐
Healthcare Benefit Trust (HBT) Policy #50168 ☐

Claim for Long Term Disability Benefits

CLAIMANT'S STATEMENT OF CONTINUING DISABILITY – FORM A

Complete and return to Canada Life at the address indicated below:

☐ Vancouver: Suite #1500–1055 Dunsmuir Street, Vancouver, BC V7X 1K8
☐ Langley: Suite #500 – 19933 – 88th Avenue, Langley, BC V2Y 4K5
☐ Calgary: Suite #1700 – 530 – 8 Ave SW, Calgary, AB T2P 3S8

PLEASE PRINT

Division Number: ___ ___ ___ **HBT Benefits ID No. (BID)** _____

Name: _____
Last First Initial

1. Describe any changes in your condition since last report (include details of any hospitalizations). _____

2. Have you been in a motor vehicle accident since your claim commenced? ☐ No ☐ Yes
If "yes", indicate date ___ ___ ___ (Day Month Year)

3. How often have you seen your regular doctor since last report? ☐ Weekly ☐ Monthly ☐ Bi-Weekly
☐ Other _____

4. a) Have you seen any other physicians/specialists since last report? ☐ No ☐ Yes
b) If "Yes", list below - all physicians/specialists you have seen. **(Attach copies of all available specialists' reports.)**

Physician's/ Specialist's Name	Address	Specialty	Dates Seen From	To

5.

Investigations Since Last Report (e.g. EKG'S, x-rays, lab tests, etc.)	Date Carried Out	Summary of Results (Attach copies of all available reports.)

6. Are any further investigations planned? ☐ No ☐ Yes If "Yes", state type and when _____

7. a) Have you worked since last report? ☐ No ☐ Yes

b) If "Yes", when did you begin working? ___ ___ ___ (Day Month Year)

Indicate: ☐ Full-time ☐ Part-time ☐ Usual job ☐ New job/duties

If "No", when do you expect to return to your previous or any other job? Day | Month | Year

c) Have you received any earnings since your last report? ☐ No ☐ Yes

d) Are you retraining or planning to do so? ☐ No ☐ Yes If "Yes", give details on a separate sheet.

e) List any courses you have taken this year: _____

f) Are you capable of driving? ☐ No ☐ Yes If "No", what alternative forms of transportation do you use?

_____

g) Have you done any volunteer work? ☐ No ☐ Yes If "Yes", give details on a separate sheet.

h) State your daily routine: _____

_____

8. Have you applied for any other disability income? ☐ No ☐ Yes

9. Have you received, or are you receiving any other disability income? ☐ No ☐ Yes If "Yes", complete this section:

Type of Disability Income	Monthly Amount	Commencement Date	Termination Date
WorkSafeBC Claim #: _____			
ICBC Claim #: _____			

Canada Pension Plan Applied Day | Month | Year

Other (e.g. legal actions, retirement benefits): _____

Note: Attach copies of correspondence you have received related to the above.

Protecting Your Personal Information

This section explains how your personal information will be used to administer your Long Term Disability (LTD) claim. The Trust and Canada Life respect your privacy and keep your personal information (including medical information) in confidential files. Only those who need your personal information to perform their duties, those to whom you grant access and those with a legal right to access your personal information will have such access. Any reference to "Trust" in this authorization section means one of the Trusts indicated on the first page, the Trustees of that Trust, their agents (including the Healthcare Benefit Trust where the Trust is not the Healthcare Benefit Trust) and Canada Life.

By signing this Form, I authorize the Trust to:

- collect, use and disclose my personal information (non-medical and medical), if reasonably necessary to (1) investigate, assess and/or administer my claim (including, but not limited to rehabilitation and return to work planning) or (2) administer the LTD Plan (including, but not limited to, auditing the LTD Plan). To clarify, I also authorize an exchange of my personal information among the Trust and its agents for those purposes;
- exchange my personal information (non-medical and medical) with any physician; health practitioner; healthcare or rehabilitation provider; independent medical examiner; any person who has or who may in the future, examine, treat or diagnose me; any hospital or clinic where I have or may become a patient; or any insurance company or any other organization with records or knowledge of me or my health, if the exchange is reasonably necessary to investigate, assess and/or administer my claim;
- exchange with my employer(s), my non-medical personal information as is reasonably necessary to investigate, assess and/or administer my claim or to assist my employer manage my absence, including rehabilitation and return to work planning. This may include information about my restrictions, limitations, abilities, and prognosis for rehabilitation and return to work.
- Claimants who are members of a union: Exchange with my union and/or bargaining association, my non-medical personal information as is reasonably necessary to assist my union and/or bargaining association to (1) represent me in respect of my claim, (2) bargain collectively in respect of the LTD Plan or (3) otherwise discharge its duties as my union/bargaining agent in respect of the benefits that are provided by the Trust including, without limitation, the Early Retirement Incentive Benefit program if it is part of the LTD Plan in which I participate.

By signing this Form, I declare that:

- my authorization will be effective until all aspects of my claim are complete including (but not limited to), the investigation, assessment and administration of my claim and any appeals, even if aspects occur after my benefits cease;
- I understand that the Trust must collect, use and disclose my Social Insurance Number to administer my claim;
- the statements I make on this Form and in the course of any personal or telephone interviews that relate to my claim, will be true and complete, and I understand that any benefits I receive are dependent on the truth of those statements.

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

Date: _____ **Telephone Number:** _____