

Disability claim form

Initial assessment

The Anglican Church of Canada

In order to ensure confidentiality of personal information, The Pension Office Corporation, Managed Disability Resources, Inc. and Standard Life will establish a disability claim file in which information concerning all of your disability claims will be kept. Only employees or authorized agents of The Pension Office Corporation, Managed Disability Resources, Inc. and Standard Life responsible for the management of your claim shall have access to the file.

Instructions for:
A. The participant:

1. Please complete the “Participant statement” section.
2. Please ensure that the Employer completes the “Employer statement” section.
3. Please ensure that your physician completes the “Attending physician statement – Psychological conditions” if the primary reason for your absence from work is psychological or the “Attending physician statement – Physical conditions” for all other conditions. As well, please provide your physician with a copy of your completed Participant statement so that the physician will have your signed authorization to release information to Managed Disability Resources, Inc. and The Standard Life Assurance Company of Canada.
4. Please note that any costs incurred in the completion of the “Attending physician statement” are your responsibility.
5. Please ensure that all of the above-mentioned forms are submitted on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.
6. Please note that Long Term Disability (LTD) benefits are reduced by certain benefit payments including those made by CPP / QPP (disability) and Worker’s Compensation. It is the responsibility of the employee to repay any overpayments that occur as a result of eligibility for these types of benefits for periods in which LTD was also paid.

B. The Employer:

1. Please complete the “Employer Statement” section.

C. The Physician:

1. Please complete the appropriate “Attending Physician’s Statement”, depending on the nature of the primary diagnosis.

How this claim will be assessed

For the first 22 months that a Participant is considered disabled, Managed Disability Resources, Inc. assesses the claim.

If the Participant continues to be disabled beyond 22 months, Standard Life will then take over the management of the claim. However, Standard Life will work with Managed Disability Resources, Inc. as of the 16th month of disability to ensure the seamless transition of the claim.

The goal of both organizations is to ensure that claims are assessed in a timely manner and that those Participants who possess the potential to return to work receive support and assistance in returning to part-time or full-time employment.

By working together, Managed Disability Resources, Inc. and Standard Life can reduce the number of forms that you need to complete.

For example, this form is the only initial disability claim form a Participant needs to complete. Those Participants who will transition to Standard Life will not need to complete another form specifically for this transition. Managed Disability Resources, Inc. will simply transfer the information they have to Standard Life at the appropriate time.

You can be confident that whether a claim is managed by Managed Disability Resources, Inc. or Standard Life, that experienced disability professionals will provide superior service and expert claims management on each and every claim submitted on behalf of The Anglican Church of Canada.



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Send claims to:

Executive Director
 Pension Office Corporation
 625 Church Street, Suite 401
 Toronto, ON, M4Y 2G1

Participant statement

To be completed by the participant. Please note that all questions must be answered in as much detail as possible.

Section A – General information

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Other	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (YYYY/MM/DD) / /	Policy no. 1 5 0 6 5	Certificate number
Surname	Given name(s)	Middle Name	Social insurance number	
Address (no., street)				
City	Province	Postal code	Telephone no. ()	Language: <input type="checkbox"/> English <input type="checkbox"/> French
Name of employer (and division if different)		Occupation (just prior to last day worked)		Original date of hire (YYYY/MM/DD) / /
Tax exempt <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state reason.				
Other current employer <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please name.				

Section B – Claim information

Was the reason you stopped working due to:
 Illness Injury away from work Motor vehicle accident (not while working) Occupational illness or work accident
(If the reason was a motor vehicle accident, please submit a police or collision report, except in Québec.)

If you have suffered an injury, please describe how, when, and where the injury occurred.

What was the last day you worked? (YYYY/MM/DD) / /	Were you performing: <input type="checkbox"/> Your regular duties <input type="checkbox"/> Modified duties	Was this a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, how many hours did you work on your last day?
What was the date you were first unable to work? (YYYY/MM/DD) / /	When did you first notice these symptoms? (YYYY/MM/DD) / /	When were you first treated by a physician? (YYYY/MM/DD) / /	

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? Yes No
 If Yes, please provide the dates and name(s) of physicians who treated you at the time.

Please describe the major duties of your occupation.

Please describe why you are unable to perform the duties of your occupation.

Do you have an expected date of return to work? Yes No If Yes, please provide the date (YYYY/MM/DD) / /

Participant statement (continued)

Section C – Health care professional information

Please list all of the health care professionals you have consulted in the last 12 months, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name	Consulted from	(YYYY/MM/DD)	to	(YYYY/MM/DD)
Address (no., street)				
Telephone no. ()	Fax no. ()	Specialty		
Name	Consulted from	(YYYY/MM/DD)	to	(YYYY/MM/DD)
Address (no., street)				
Telephone no. ()	Fax no. ()	Specialty		
Name	Consulted from	(YYYY/MM/DD)	to	(YYYY/MM/DD)
Address (no., street)				
Telephone no. ()	Fax no. ()	Specialty		

Section D – Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable:

Source	Claim no., contact name, telephone no.	Have you applied?		Are you receiving payment?			Monthly Amount
		Yes	No	Yes	No	Pending	
Worker's Comp / CSST		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan - Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan - Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (RRQ) - Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (RRQ) - Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auto Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Insurer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Section E – Participant authorization and declaration

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer, or any other person or organization in possession of information concerning myself to release to Managed Disability Resources, Inc. and The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Managed Disability Resources, Inc. and Standard Life, permitting the assessment of my claim.

I authorize Managed Disability Resources, Inc. and The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Managed Disability Resources, Inc. and Standard Life and/or their authorized agents will use the information provided in this form and in my pertinent prior claims under the same plan for the management of my claim and for production of statistical reports.

I consent to the use of my Social Insurance Number as my membership number under the plan as an identifier in Managed Disability Resources, Inc. and Standard Life's database, and that it is my responsibility to contact my employer if I prefer to use another identification number.

I acknowledge that disability benefits from either the Canada Pension Plan or the Quebec Pension Plan are direct offsets from my LTD benefits and that I will ensure that these amounts will be reimbursed when received. I further acknowledge that benefits paid by Worker's Compensation (WCB/WSIB/CSST) as a result of a work-related incident are also direct offsets from my LTD benefit and that I will ensure that these amounts will be reimbursed when received. In the event that an overpayment of benefits exists from the Long Term Disability Plan of The Anglican Church of Canada, I agree to repay the full amount owed from my LTD benefits payable by the Pension Office Corporation or Standard Life, whichever is applicable, until the overpayment is recovered in full.

I certify that the information contained in this form is true and complete.

A photocopy of this authorization is valid as the original.

Name (please print) 15065 Policy no.	Signature / / Date (YYYY/MM/DD)
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 625 Church Street, Suite 401
 Toronto, ON, M4Y 2G1

Employer Statement
To be completed by the Employer. All questions must be answered in as much detail as possible.

Section A – Employer information

Name of Employer The Anglican Church of Canada	Name of Diocese
Address	

Section B – Participant information

Surname	Given name	Middle Name
Policy no. 1 5 0 6 5	Division no.	Class no.
Social insurance number	Certificate no.	Permanent employee? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the employee live in a rectory? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Please provide the date on which this participant was first covered under this policy: (YYYY/MM/DD)		
Was the coverage in force when the absence began / loss occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please comment		

What was the participant's: date of hire? (YYYY/MM/DD)	last date of work? (YYYY/MM/DD)
If already back at work, what was the start date? <input type="checkbox"/> Part-time (YYYY/MM/DD)	<input type="checkbox"/> Full-time (YYYY/MM/DD)

What was the participant's main reason for absence:
 Illness Injury away from work Motor vehicle accident (not while working) Occupational illness or work accident Unknown

Please indicate the hours of work in a normal week:
 Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____
(If shift work, please provide work schedule)

What was the participant's gross weekly salary (for pension purposes) as of his / her last day of work? \$ _____

If the employee resides in a rectory, what is the weekly value of the housing? \$ _____	Was the participant: <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
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Personal income tax exemptions: Federal \$ _____ Provincial \$ _____	Personal income tax claim/deduction code: Federal _____ Provincial _____
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Did the participant receive any income during the disability period? Yes No
 If Yes, please select one of the following:
 Vacation Maternity leave Employment insurance Sick days Statutory holidays Other _____
 Amount \$ _____ From (YYYY/MM/DD) _____ to (YYYY/MM/DD) _____

Has the participant submitted a claim to the following government bodies?
 WSIB / WCB / CSST EI CPP QPP (RRQ) Provincial automobile insurance board



Employer Statement *(continued)*

Section C – Occupational information

What was the participant’s regular occupation immediately prior to his/her stopping work?

Were the participant’s duties modified from his/her regular occupation? Yes No

Please describe this employee’s regular occupation *(or attach a copy of the company’s job description)* as well as any modifications, if any.

The following physical demands analysis of the participant’s occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time *(in hours)* the following activities are regularly performed:

I) at any one time without a break *(approximately)* and;
 II) in total throughout the day *(approximately)*

Physical demands analysis

		I	II
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down the stairs			
6. Lifting	0 - 10 pounds <input type="checkbox"/> 10 - 20 pounds <input type="checkbox"/> 20 - 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/> with lifting device? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Pushing/Pulling	0 - 10 pounds <input type="checkbox"/> 10 - 20 pounds <input type="checkbox"/> 20 - 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/>		

Please describe work environment *(i.e. temperature, noise levels, chemical/dust exposure, etc.)*

Does the participant wear personal protective equipment *(i.e. safety glasses/footwear, respiratory protection, ear protection, etc.)*?
 If Yes, please describe.

I certify that the information given above is true and complete. Date (YYYY/MM/DD)

Name *(please print)* Telephone no.

Signature of the authorized person Job title



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 625 Church Street, Suite 401
 Toronto, ON, M4Y 2G1

Attending physician statement (Physical conditions)
In order for the employer or its agents to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Surname		Given name	Middle Name
Date of birth	(YYYY/MM/DD)	Height	Weight
		/	/

Section B – Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occurred? (YYYY/MM/DD)

What was the date of the patient's first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient's first visit during the present period of absence from work? (YYYY/MM/DD)

If the patient has a cardiac condition, what is his/her current functional capacity based on the American Heart Association classifications:
 Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Severe Limitation)

What is the patient's blood pressure? Current _____ Previous _____ (YYYY/MM/DD)

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed? Yes No
 If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? Yes No
 If Yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should not** do)? Please be specific.

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

If a potential return to work date has been discussed, please provide the date. (YYYY/MM/DD)



Attending physician statement (Physical conditions) (continued)

Has the patient ever had the same or similar condition? Yes No If Yes, please provide dates and describe.

Is the patient's condition due to injury or sickness arising out of his/her employment? Yes No If Yes, please elaborate.

If the patient was/is pregnant, please indicate the date or expected date of confinement. (YYYY/MM/DD)

_____ / _____ / _____

Section C – Treatment

Frequency of patient visits: Weekly Bi-weekly Monthly Other _____

Please detail the patient's past and present treatment (e.g. date and type of surgery) as well as response to treatment.

Has the patient been hospitalized? Yes No If Yes, please provide the name of the hospital(s) and the dates of confinement.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)
		_____ / _____ / _____
		_____ / _____ / _____
		_____ / _____ / _____
		_____ / _____ / _____

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Signature (YYYY/MM/DD)

_____ / _____ / _____

Name (please print)	Specialty
Address (no., street)	
Telephone no. () ()	Fax no. () ()



Send claims to:

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Pension Office Corporation
625 Church Street, Suite 401
Toronto, ON, M4Y 2G1

Attending physician statement (Psychological conditions)

In order for Standard Life to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

Section A – Information about the patient

Form with fields for Surname, Given name, Middle Name, Date of birth, Height, and Weight.

Section B – Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

Form with five rows for diagnosis categories I, II, III, IV, and V.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? Yes No If Yes, please elaborate.

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

Please describe the patient's initial reason for seeking treatment. Was there a precipitating event?

What was the date of the patient's first visit for his/her current condition? When did symptoms first appear?

What was the date of the patient's first visit during the present period of absence from work?

Is your patient's condition caused directly or indirectly by his/her employment? Yes No If Yes, please elaborate.

What are the patient's current limitations (things that he/she cannot do)? Please be specific.

What are the patient's current restrictions (things that he/she should not do)? Please be specific.

Please indicate the date the patient stopped working based on your recommendation.

If a potential return to work date has been discussed, please provide the date.

Attending physician statement (Psychological conditions) *(continued)*

Section C – Treatment		
Frequency of patient visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Please detail the patient’s past and present treatment <i>(including psychotherapy)</i> , response to treatment, and compliance.		
Has the patient been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the name of the hospital(s) and the dates of confinement.		
Please list all of the medications that the patient is currently taking, including dosage and date prescribed.		
Medication	Dosage	Date prescribed (YYYY/MM/DD)
		/ /
		/ /
		/ /

Section D – Functional capacities evaluation					
Please provide your opinion as to the extent of the patient’s impairment in performing the following on a sustained basis: None: No impairment in this area Mild: Suspected impairment of slight importance which does not affect functional ability. Moderate: Impairment affects but does not preclude ability to function. Moderately Severe: Impairment significantly affects ability to function. Severe: Extreme impairment of ability to function.					
	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ability to attend to personal care <i>(bathing, cooking, etc.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Perform work where contact with others will be minimal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Understand, carry out, and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Make independent judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____		(YYYY/MM/DD) / /
Name <i>(please print)</i>	Specialty	
Address <i>(no., street)</i>		
Telephone no. ()	Fax no. ()	

**Retirement
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The Standard Life Assurance Company of Canada

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