PLAN MEMBER GUIDE AND APPLICATION FOR EARLY INTERVENTION SERVICES

This guide is designed to assist you in the application submission process

GL2337 (04/17)

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PLAN MEMBER GUIDE AND APPLICATION FOR EARLY INTERVENTION SERVICES

EARLY INTERVENTION SERVICES

Early Intervention services are intended to assess your absence from work for the purposes of salary continuance and may include assisting with recovery and early return to work planning.

Please check with your plan sponsor to confirm when to submit your application.

THE FOLLOWING INFORMATION IS REQUIRED:

Plan Member Statement

Asks general information about you, your occupation and the nature of your disability for the purpose of assessing your absence. Please complete all questions on this form and be sure to include your group number.

Attending Physician Statement

Ask your physician to complete the form. Ensure that your physician includes copies of test results, specialist reports and any additional information that may assist us with your application.

You are responsible for providing medical proof to support your absence from work. Your physician may request a fee for completing claim forms which will be your responsibility. If we request information directly from your physician, we may offer to pay your physician a correspondence fee.

Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

CLAIM INTERVIEW

A Co-operators Life Insurance Company representative may telephone you to obtain information about your occupation, education and employment history, medical history, and current condition.

CANADA PENSION PLAN/QUEBEC PENSION PLAN (CPP/QPP) DISABILITY BENEFITS

If you have already applied for CPP/QPP disability benefits, then please include your Notice of Entitlement with your application. If you have not applied, we may require you to submit an application for CPP/QPP benefits.

WORKERS' COMPENSATION BENEFITS

If you have applied for Workers' Compensation, you must still submit your application for Early Intervention services. This will ensure that your application is received within the prescribed time limits.

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give Co-operators Life Insurance Company permission to obtain this information from your treatment providers, your plan sponsor, other insurers and hospitals where you received treatment.

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business. Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in it custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to your booklet or our website at www.cooperators.ca/en/PublicPages/Privacy.aspx

CONTACT INFORMATION

If you have any questions or if you need help with this application, please contact your plan administrator or our office at 1-866-442-3098. Please have your group policy and certificate number available.

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GROUP BENEFITS EARLY INTERVENTION PLAN MEMBER STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Disability Claims Department
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9926

Email: disability_claims_admin@cooperators.ca

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

If illness/injury is claimed to be work related, you must make an application to Workers' Compensation in addition to this plan.

1. PLAN MEMBER INFORMATION

Plan Member ______________________ ______ ______________________
First Name Initial Last Name

Group ______________ Account ______________ Certificate ______________

Date of Birth ______________ (MMM/DD/YYYY) ☐ Male ☐ Female Height ________ Weight ________

Address ______________________ ______________ ______ ______________
Street City Province Postal Code

Phone Number (______)______________ Cell Number (______)______________

If you would like The Co-operators to communicate with you by email about this disability claim, please provide your email ______________________

We use reasonable safeguards to protect all information collected, used, retained and disclosed in the course of conducting business; however, email may be vulnerable to interception by unauthorized parties. We discourage you from emailing personal or sensitive information. If you provided your email to us, or if you contacted us by email, we accept this as your consent to communicate with you by email. If you do not wish for us to communicate with you by email, please notify us at your earliest convenience.

Plan Sponsor/Employer ______________________________ Phone Number (________)______________

2. CLAIM INFORMATION

Describe your present medical condition, its cause and history ______________________________

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Date Symptoms Began ______________ (MMM/DD/YYYY) Date of first treatment for this illness/injury ______________ (MMM/DD/YYYY)

Medical condition has prevented me from working since ______________ (MMM/DD/YYYY)

Have you ever had a similar injury or illness in the past? ☐ Yes ☐ No

If yes, please describe your condition, the date of its onset, any treatment you received for it, and any time lost from work because of it.

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If your condition is the result of an injury or motor vehicle accident, please describe the events surrounding the injury/accident.

Date ______________ (MMM/DD/YYYY) Time ______________

Details ____

____

Was this a work related injury? ☐ Yes ☐ No

List all physicians you have seen for your present medical condition (ensure copies of all available specialists' reports are provided):

Physician	Address	Dates Seen (MMM/DD/YYYY) From	To	Next Appointment Date (MMM/DD/YYYY)

Plan Member ______________________ ______ ______________________
First Name Initial Last Name

2. CLAIM INFORMATION (CONTINUED)

List any dates of hospitalization From ______________ To ______________
MMM/DD/YYYY MMM/DD/YYYY

Has your physician told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, describe what he/she told you about restricting your activities ______________________

How do these restrictions interfere with your ability to perform your job duties? ______________________

Have you discussed a return to work with your employer? ☐ Yes ☐ No

☐ Own Occupation	☐ Modified Occupation	☐ Part-Time	☐ Full-Time
Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY

Have you discussed a return to work with your physician? ☐ Yes ☐ No

☐ Own Occupation	☐ Modified Occupation	☐ Part-Time	☐ Full-Time
Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY	Date ________ MMM/DD/YYYY

3. OCCUPATION INFORMATION

Present Employment

Occupation ______________________ Date Started ______________
MMM/DD/YYYY

Duties ______________________

Previous Employment

If you have been in your current role less than 2 years, please provide details of your previous position.

Employer ______________ Job Title ______________ Dates of Employment ______________

Duties ______________________

4. PRIVACY

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Co-operators Life Insurance Company will collect, use and disclose personal information about you, your spouse or dependents for the purposes of providing group benefit plan administration, underwriting and claim services. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. Your personal information may be collected by or transferred to a service provider outside of Canada for processing, storage, analysis or disaster recovery. You can find more details about Co-operators Life Insurance Company's privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact: The Co-operators Privacy Officer: Priory Square, Guelph ON N1H 6P8 Tel: 1-888-887-7773 email: privacy@cooperators.ca (please indicate Co-operators Life Insurance Company in your inquiry).

5. PLAN MEMBER AUTHORIZATION

I have read and understood the section entitled "Privacy" and I consent to the collection, use and disclosure of my personal information for the purposes stated. I acknowledge that Co-operators Life Insurance Company may provide supportive Early Intervention services to me prior to the date upon which I may, if at all, become eligible to receive Long Term Disability (LTD) benefits and that these services provided by Co-operators Life Insurance Company will not in any way be construed as an admission of liability by Co-operators Life Insurance Company or acceptance of a claim for the payment of LTD benefits.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, the group plan administrator or its representatives, any insurance company, government agency or my employer to release to Co-operators Life Insurance Company or its representatives or agents, any and all medical, employment or vocational information or records regarding me for the following purposes: to provide early intervention services that may include the evaluation, administration and management of my medical absence from work, and to assess and facilitate my return to work. I further authorize Co-operators Life Insurance Company or its representatives or agents to disclose any such information obtained during the course of my early intervention file to any physician, clinic or any other medical or health care provider or facility for such purposes.

I understand that my refusal or withdrawal of consent may delay the provision or result in the denial of such services. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to this medical leave application are/will be true, complete and accurate.

In the event I do not return to work and I submit an application for Long Term Disability benefits, I understand and authorize that my entire Early Intervention file will form part of my Long Term Disability file.

This authorization shall remain valid for the duration of the provision of early intervention services unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Plan Member Signature ______________________ Date ______________
MMM/DD/YYYY