Group Life & Health

Disability claim form – initial assessment

Disability claims department

Montréal
P.O. Box 4002 STN B
Montréal, Québec H3B 4M2

Toronto
P.O. Box 4105 STN A
Toronto, Ontario M5W 2P4

Calgary
P.O. Box 1315 STN M
Calgary, Alberta T2P 2L2

Fax: 1-866-645-4180
Tel: 604-664-8010
1-800-663-1784

Please keep the original documents faxed to Standard Life.

Instructions for:

A. The Plan Member:

1. Please complete the "Plan Member Statement" section.
2. 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 Plan Member Statement so that he/she will have your signed authorization to release information to The Standard Life Assurance Company of Canada.
3. Please note that any costs incurred in the completion of the "Attending Physician Statement" are your responsibility.
4. Please ensure that all of the above-mentioned forms are submitted to Standard Life within 30 days, sending them in together in order to avoid unnecessary delays in the assessment of your claim.
5. Please complete the direct deposit authorization at the bottom of the next page to have your benefits deposited directly into your bank account, should your claim be approved.

Plan Member's Statement

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

Section A – General information

☐ Mr. ☐ Mrs. ☐ Ms. Gender: ☐ Male ☐ Fémale | Date of birth *(YYYY/MM/DD)* | Policy no. **32548** | Member no.

Surname | Given name(s) | Initial | Social insurance number

Address *(no., street)*

City | Province | Postal code | Telephone no. | Language: ☐ English ☐ French

Name of plan sponsor **(and division if different)**
Carpentry Worker's Benefit Plan of B.C.

Are you Tax exempt ____________ If Yes, please state reason ____________

What was your occupation when you became disabled ____________

Section B – Claim information

Was the reason you stopped working due to:
☐ Illness ☐ Injury away from work (Please note: Disabilities resulting from motor vehicle accidents and occupational illnesses or work accidents are not covered under this plan)

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)*

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.

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

If your disability is the result of an accident are you taking legal action against any other person or organization? ☐ Yes ☐ No

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Plan Member's 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	

Section D – Other income information

Have you applied for, or are you receiving any income from other sources? If so, please advise from where and what amount.

______________________________ $_______________

Section E – Plan Member authorization and declaration

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

I authorize 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 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 Standard Life's database, and that it is my responsibility to contact my plan sponsor if I prefer to use another identification number.

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)*	Signature
Policy no.	Date *(YYYY/MM/DD)*

Direct deposit authorization

Policy no.	Member no.	Member surname	Given name(s)	Initial
32548				

Financial institution name	Financial institution address

Type of bank account: ☐ Chequing ☐ Savings

Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

Direct deposit:	Branch no.	Institution no.	Account no.

I authorize Standard Life to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Standard Life of any subsequent changes. I accept that this agreement may be cancelled at any time by either Standard Life or myself, in writing or verbally.

Member signature	Date *(YYYY/MM/DD)*
Account holder signature *(if other than member)*	Date *(YYYY/MM/DD)*

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