BRITISH COLUMBIA
BC Public Service

Where ideas work

To the Employee

Checklist for Submitting Your Application for Long Term Disability (LTD) Benefits

Please note: Employees must submit all portions of their completed LTD Plan application, including the Physician* portion, within four weeks following the end of the STIIP period. If an employee fails to submit their application within that time, they will be presumed to have abandoned their claim. If an employee has not abandoned their claim, they must then demonstrate to the plan administrator that there were reasonable grounds for not having applied during the prescribed period.

- ☐ **Please read the Guide to Applying for LTD. It contains important information and provides helpful questions and answers.**
- ☐ **Your Physician* will require a signed authorization from you, so the necessary medical documents can be released to Canada Life and the Plan Administrator. Please complete the form on page 14 and provide it to your Physician*.**
- ☐ **Have your Physician* complete the Attending Physician* Initial Statement and Psychiatric Condition Statement, if required, and attach any test results or reports from specialists. You can provide the forms to your Physician or they can obtain the forms online at www2.gov.bc.ca/myhr and can be emailed to Vancouver.DMSO@CanadaLife.com, mailed or faxed to the address below. Should all the information not be received from your Physician*, it will delay your claim. If your Physician does not have copies of specialists' reports, you can obtain them directly from the specialist.**
- ☐ **Complete ALL sections of the "Employee's Long Term Disability Application." Attach any information concerning your claims for CPP, WCB and/or ICBC benefits.**
- ☐ **Summary of Education, Training and Experience Form. This information is not necessary at the time of your initial application but may be required at a future date. Canada Life will advise you if/when this information is needed.**
- ☐ **Complete the Direct Deposit Authorization Form and attach a sample cheque marked "void."**
- ☐ **Please return your completed LTD forms by email, fax or mail to the address below:**

Canada Life Assurance Company
Suite 1500 - 1055 Dunsmuir Street
Vancouver BC V7X 1K8
Toll Free: 1-888-292-4111
Fax: 1-844-816-1038
Email: Vancouver.DMSO@CanadaLife.com

*** Effective April 1, 2022, BC General Employees' Union, Professional Employees' Association, and excluded employees may have their LTD application forms completed by an attending Nurse Practitioner. Please refer to your collective agreement or terms and conditions of employment for further information.**

Remember to retain copies of all forms for your personal records.

CLEAR FORM

BRITISH COLUMBIA BC Public Service | Where ideas work

Employee's Long Term Disability Benefit Application

Freedom of Information and Protection of Privacy Act (FOIPPA) The personal information requested on this form is collected under the authority of FOIPPA s.26(c) and will be used to process your application for Long Term Disability benefits and for return-to-work planning. Questions about the collection or use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request at AskMyHR, phoning 1-877-277-0772, or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard St. Victoria, BC V8W 2H2.

Identification

First Name	Initial	Last Name	

Address: Number & Street Name	Suite Number	Employee Number

City	Province	Postal Code
	British Columbia	

Home Email	Home Phone	Work Phone

Social Insurance Number	Occupation	Date of Birth (yyyy-mm-dd)	Age

Employer	Department	Supervisor	Start Date in Present Position:

Claim Information

Please explain how your condition is affecting you and specifically outline how it prevents you from working or participating in other activities.

If illness or injury is due to an accident, give date accident occurred: (yyyy-mm-dd):	From what date has your illness or injury continuously prevented you from working? (yyyy-mm-dd)

Have you performed any other work since that date? ◯ Yes ◯ No

Have you had this condition before? ◯ Yes ◯ No

Medical Treatment

Name and address of the physician* currently supervising your treatment:

Name

Address (Suite, Street Number, Street Name, City, Province)

Name(s) and address(es) of other physician(s)* who have treated you for this condition:

Name	From (yyyy-mm-dd)

Address (Suite, Street Number, Street Name, City, Province)	To (yyyy-mm-dd)

Were you confined to hospital due to this condition?: ◯ Yes ◯ No

Financial

Have you applied for, or are you receiving the following:	I have applied		I am receiving			
	Yes	No	Yes	No	Amount	
Canada Pension Plan/Quebec Pension Plan Benefits	◯	◯	◯	◯		$ per mo.
Workers' Compensation Board Benefits	◯	◯	◯	◯		$ per wk.
Employment Insurance Benefits	◯	◯	◯	◯		$ per wk.
Automobile Insurance Benefits	◯	◯	◯	◯		$ per wk.
Any Other Disability Benefits	◯	◯	◯	◯		$ per wk.
Retirement/Pension Income	◯	◯	◯	◯		$ per wk.
Self Employment or any other Employment Income	◯	◯	◯	◯		$ per wk.
Any Other Income	◯	◯	◯	◯		$ per wk.

For the duration of your claim for benefits, you are required to notify Corporate Health Programs in the BC Public Service Agency of:

- any monies received from the above sources,
- any work performed, whether or not you have received a wage or remuneration, or
- any employment income paid to you or any other person or party as a result of work performed by you.

If you are receiving any of the above, please attach copies of all benefit statements.

Safeguarding Your Personal Information

This authorization must be submitted together with your application for Long Term Disability Benefits.

At the British Columbia Public Service Agency (BCPSA) and The Canada Life Assurance Company (Canada Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of BCPSA and Canada Life. This personal information may include medical and psychiatric information. We limit access to the information in your files to the appropriate BCPSA and Canada Life staff, to persons authorized who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by you. The information is used to investigate and assess your claim and to administer the Long Term Disability Plan.

I authorize Canada Life, any physician, healthcare or rehabilitation provider, my plan administrator, other insurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange my personal information when relevant and necessary for the purpose of Canada Life's assessment of my claim, administering the group benefit plan, or performing independent medical assessments;

I authorize Canada Life and BCPSA Occupational Health Programs to exchange my personal information when relevant for the purpose of Canada Life's assessment of my claim or in my rehabilitation and return to work support;

I authorize Canada Life, my plan administrator and Workplace Health Services to exchange information when relevant for the purpose of discussing rehabilitation and return-to-work planning;

I authorize Canada Life and the Claims Review Committee to exchange my personal information for the purpose of resolving a dispute about my benefit entitlement;

I authorize Canada Life to release information about my claim to an auditor authorized by my employer, plan administrator or their agent and Canada Life at any time for the purpose of auditing the assessment of claims;

I authorize the use of my Social Insurance Number for income tax reporting purposes and as an identification number only where required in the administration of my claim.

Except for audit purposes, this authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Claimant's Statement and any statements provided in any personal or telephone interview concerning this claim for disability benefits will be true and complete. I agree that all such statements form the basis for any benefits approved as a result of a claim.

Name (please print)	Telephone Number

Signature	Date (yyyy-mm-dd)
X	

Employee Name	Employee Number

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Summary of Education, Training and Experience (Employee's LTD Benefit Application)

This information is not necessary at the time of your initial application but may be required at a future date. Canada Life will advise you if/when this information is needed.

Identification

Name	Social Insurance Number

Education

Level	Location	Level Obtained	Year	Areas of Study and Years Completed
Elementary or High School				
College or University				
Other (Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.). Attach additional pages if necessary.				

Work Experience

(Begin with the most recent and include every job you have had. Attach extra sheets if necessary, or your resume.)

Duration of Employment		Employer	Job Title and Duties
From (yyyy-mm-dd)	To (yyyy-mm-dd)		
From (yyyy-mm-dd)	To (yyyy-mm-dd)		
From (yyyy-mm-dd)	To (yyyy-mm-dd)		

Acquired Skills

(These may include typing, operation of equipment, supervisory skills, special licenses, etc. Where appropriate, give level, speed or proficiency.)

Volunteer work, hobbies and interests:

Do you have a valid driver's licence? ◯ Yes ◯ No

Signature	Date (yyyy-mm-dd)
X	

Employee Name	Employee Number

Direct Deposit Authorization
Long Term Disability Benefit Payments

Social Insurance Number	Employee Number	Employee Name	Home Telephone Number

I wish to have my Long Term Disability payments deposited to:

- ◯ My chequing account – I have attached a sample cheque marked "Void"
- ◯ My savings or other account – Details supplied below

Direct Deposit Service available for institutions within Canada only.

Please Print

Name of bank or other financial institution		

Transit Number	Institution Number	Account Number

Branch Address (Suite, Street Number, Street Name)	Name in which account is held	

City	Province	Postal Code
	British Columbia	

Signature	Date signed (yyyy-mm-dd)
X	

This authorization MUST be submitted together with your application for Long Term Disability Benefits.

Claimant's Authorization	
I hereby authorize the release to Canada Life and Corporate Health Programs at the BC Public Service Agency, my LTD plan administrator of any relevant information requested on this form and the Psychiatric Condition Statement in respect of this claim.	
Signature X	Date signed (yyyy-mm-dd)

For the Physician*

An electronic version of the Attending Physician* Initial Statement (LTD Medical Form) is available at www2.gov.bc.ca/myhr. Search for LTD Application which will provide the Guide, the Attending Physician's Statement and the Application Form.

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Employee Name	Employee Number