Canadian Group Long Term Disability

MAIL, FAX or EMAIL TO: Cigna
Attn: Team Foy
P.O. Box 16491
Pittsburgh, PA 15242
Facsimile: 860.752.6750
TeamFoy@Cigna.com

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York

CLEAR FORM

FRAUD NOTICE: Any person who knowingly files a claim containing false or misleading information is subject to criminal and civil proceedings.

TO BE COMPLETED BY THE EMPLOYEE

PLEASE TYPE OR PRINT. BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM
USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY

NAME (*Last, First, M.I.*)	SOCIAL INSURANCE NO. *(Only required when disability benefit is taxable)**	SEX ☐ M ☐ F	DATE OF BIRTH (DD/MM/YY)

MAILING ADDRESS *(Address where you may be reached during the next six months)*	PHONE NUMBER *(Includes Area Code)*

NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH (DD/MM/YY)	IS SPOUSE EMPLOYED? IF YES, ☐ Yes ☐ No	☐ Full Time ☐ Part Time

Do you have any children under age 18? ☐ Yes ☐ No
Do you have any children age 18-19? ☐ Yes ☐ No
Do you have any handicapped children (regardless of age)? ☐ Yes ☐ No
If you answered "Yes" to any of the above questions, please list names and dates of birth below.

NAME	DATE OF BIRTH (DD/MM/YY)

DATE OF ACCIDENT OR BEGINNING OF SICKNESS (DD/MM/YY)	DATE YOU BECAME TOTALLY DISABLED (DD/MM/YY)	DATE YOU PLAN TO RETURN TO WORK (DD/MM/YY)

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, OR WORK-RELATED, DESCRIBE CIRCUMSTANCES)

NAMES OF ALL ATTENDING PHYSICIANS CONSULTED FOR THE DISABILITY	COMPLETE ADDRESS AND PHONE NUMBERS	DATE FIRST CONSULTED (DD/MM/YY)

NAMES OF HOSPITALS	COMPLETE ADDRESS	DATE ENTERED - DATE DISCHARGED (DD/MM/YY)

Have you applied for CPP/QPP Disability Benefits? ☐ Yes ☐ No
If yes, please attach a copy of your CPP/QPP notice for you and your dependents or a copy of your CPP/QPP denial. If you have not received a determination, please attach a copy of your receipt for application.
Are you covered under a life insurance policy provided by a Cigna underwriting company? ☐ Yes ☐ No
If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No

Are you receiving or eligible to receive:	$ Amount/Frequency	Date Began (DD/MM/YY)	Date Paid Through (DD/MM/YY)
☐ Yes ☐ No Salary Continuance			
☐ Yes ☐ No Employment Insurance Disability Benefits			
☐ Yes ☐ No Group Disability Benefits			
☐ Yes ☐ No WSIB/CSST/WCB/WHSCC Benefits			
☐ Yes ☐ No Pension Benefits			
☐ Yes ☐ No No-Fault Auto Disability insurance			
☐ Yes ☐ No Any other Disability Income (please identify)			

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE: _____ **DATE (DD/MM/YY):** _____

*Disability benefit is taxable if Employer pays any portion of the insurance premium.

TO BE COMPLETED BY THE EMPLOYER
PLEASE COMPLETE IN FULL

NAME OF EMPLOYEE (*Last, First, M.I.*)	SOCIAL INSURANCE NO. *(Only required when disability benefit is taxable)**	POLICY NUMBER

DATE HIRED (DD/MM/YY)	EFFECTIVE DATE OF EMPLOYEE'S LTD COVERAGE WITH CIGNA CO. (DD/MM/YY)	WAS EMPLOYEE'S LTD INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? ☐ Yes ☐ No IF YES, ATTACH COPY

BASIC EARNINGS	DATE OF LAST CHANGE IN EARNINGS (DD/MM/YY)	LAST DATE(S) WORKED (DD/MM/YY)	DATE(S) RETURNED TO WORK (DD/MM/YY)
_____ Wk. _____ Mo.		# Hrs. _____	

PLEASE CHECK THE APPROPRIATE BLOCKS:

☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full Time ☐ Part Time

☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly Hrs/wk: _____

IS EMPLOYEE STILL EMPLOYED? ☐ Yes ☐ No	IF NO, DATE OF TERMINATION (DD/MM/YY)	REASON

DID EMPLOYER PAY ANY PORTION OF THE INSURANCE PREMIUM? ☐ Yes ☐ No	PREMIUM PAID THROUGH DATE (DD/MM/YY)

WAS SALARY CONTINUED BEYOND LAST DAY WORKED? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT	PAID THROUGH (DD/MM/YY)

HAS EMPLOYEE RECEIVED SHORT TERM BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT	FROM (DD/MM/YY)	THROUGH (DD/MM/YY)
HAS EMPLOYEE RECEIVED EMPLOYMENT INSURANCE BENEFITS? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT	FROM (DD/MM/YY)	THROUGH (DD/MM/YY)
HAS EMPLOYEE FILED A WSIB/CSST/WCB/WHSCC CLAIM? If yes, ☐ approved or ☐ pending? ☐ Yes ☐ No	IF YES, WEEKLY AMOUNT	FROM (DD/MM/YY)	THROUGH (DD/MM/YY)

WSIB/CSST/WCB/WHSCC CLAIM NUMBER

IS EMPLOYEE ELIGIBLE FOR GROUP PENSION ☐ Yes ☐ No	IF YES, MONTHLY AMOUNT	EMPLOYEE % CONTRIBUTION To Pension _____ %	EFFECTIVE (DD/MM/YY)	IS THIS A ☐ DISABILITY PENSION ☐ EARLY RETIREMENT ☐ NORMAL RETIREMENT

LIST ANY OTHER SOURCE OF INCOME/BENEFITS TO WHICH THE EMPLOYEE IS ENTITLED AS A RESULT OF THIS DISABILITY

OCCUPATION (ATTACH JOB DESCRIPTION IF AVAILABLE: IF NOT, DESCRIBE JOB DUTIES BELOW)

Was employee's job primarily ☐ sedentary or ☐ did it involve considerable physical activity?

AS CLOSELY AS POSSIBLE, PLEASE ESTIMATE THE PERCENT OF TIME SPENT (TOTAL PERCENTAGE MUST EQUAL 100%):

_____ Sitting _____ Walking _____ Stooping _____ Pushing _____ Carrying +

_____ Standing _____ Climbing _____ Bending _____ Lifting

+ If job duties require lifting or carrying, indicate average and maximum weights handled. _____

Is this individual covered under a life insurance policy provided by a Cigna underwriting company? ☐ Yes ☐ No

If yes, does this life insurance policy contain a waiver of premium provision? ☐ Yes ☐ No

REMARKS

EMPLOYER DIVISION

ADDRESS	TELEPHONE NUMBER

AUTHORIZED REPRESENTATIVE PRINT: SIGNATURE:	DATE (DD/MM/YY)

*Disability benefit is taxable if Employer pays any portion of the insurance premium.

CANADIAN DISCLOSURE AUTHORIZATION

Employee's Name *(Please Print)*: _____ Date (DD/MM/YY): _____

PRIVACY NOTICE: Company (defined below) will establish a claim file to which access will be restricted to Company's authorized employees and agents and to persons authorized by law or as I may authorize. I understand that the information provided by me will be used by Company, its reinsurers and authorized administrators and agents for the purposes of investigating, adjudicating, managing, and administering my claim, or otherwise providing services related to my employer's group benefit plan insured or administered by Company ("Plan"), which may include, but is not limited to, assisting me in returning to work and rehabilitation, Plan administration and identifying other coordinating benefits for which I may be eligible, including CPP Assistance Program. I understand Company will consult its existing files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. Company may communicate to my employer the decision about my claim and information about my ability to return to my job or transitional work duties, but for these purposes my employer will not be given medical diagnosis, medication and treatment information unless I provide an additional authorization to that effect. I understand my personal information may be processed and stored outside of Canada and may be accessible to foreign governments, courts or law enforcement or regulatory agencies through the laws of those foreign governments, including the United States.

I AUTHORIZE:

I AUTHORIZE: any healthcare or rehabilitation provider or professional, hospital or other medical facility, pharmacy, governmental agency, plan administrator, employee assistance plan, insurance or reinsurance company, service provider of Company or the plan administrator, health maintenance organization or similar entity to provide access to or copies of any information about my health or other information relating to me, to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to Company and any entity providing assistance to them, including CPP Assistance Program. Information may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me, and may relate to communicable diseases, genetic testing, any disorder of the immune system including, but not limited to HIV and AIDS; use of drugs and alcohol; mental and physical history, condition, advice or treatment, but does not include psychotherapy notes. If my employer offers both a disability and medical plan underwritten or administered by Company or one of its affiliates ("Company Affiliate"), the information described in this form may also be given to Company Affiliate which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for assisting me in returning to work and rehabilitation, and for administering any feature described in the Plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, Plan administrator, family members, friends, neighbors or associates, governmental agency including the WSIB/CSST/WCB/WHSCC, the CPP/QPP disability retirement authorities or any other organization or person having knowledge of me to give to any individual or entity who provides services to or insurance benefits on behalf of the Plan, any information that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I AUTHORIZE: Company to use my SIN for income tax reporting purposes *where required* in the administration of benefits.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date of execution. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original. I understand that I do not have to give this authorization and by not providing it or later revoking it may result in delay or denial of my claim.

Les parties ont expressément convenue que la présente entente ainsi que tous annexes s'y rattachant soient rédigés en anglais. (The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.) NOTE: Ce document est aussi disponible en français.

Signature of Employee or Employee's Authorized Representative: _____ Date (DD/MM/YY): _____

Relationship, if other than Employee: _____

Employee's Social Insurance Number (SIN) *(Only for tax reporting purposes)* _____

"Company" refers to the insurance company listed on your insurance policy or the claims administrator for your employer's self-insured disability plan. This form is used for coverage insured or administered by Life Insurance Company of North America, Connecticut General Life Insurance Company, and Cigna Life Insurance Company of New York. Your consent is limited to the sharing of your information with the company named on your insurance policy or your employer's plan.

CLICK TO PRINT