

**This form is to be completed by the Benefits Administrator, or applicable personnel, and submitted with the employee's application for Long Term Disability benefits**

- Upon receiving notice that an employee may be applying for Long Term Disability benefits you should remind the employee that application forms must be submitted within seven months of completion of the elimination period (1 year). Claims received after such date are considered late. Late claims are not eligible for retroactive benefit payments, meaning that benefits will only be payable from the date of application. If the claim is submitted more than 1 year late (19 months after completion of the elimination period) the Plan is not liable for benefits and the claim will not be accepted.
- Prompt assessment of Long Term Disability claims and early participation in rehabilitation programs can be promoted if Long Term Disability application forms are submitted to Health Association Nova Scotia between four and six weeks (no less than four) prior to the date that Long Term Disability benefits would begin, if approved.

Employee (Last, First, Initial)

Facility

Division

**Employer**

Employer's Statement

Job/Position Description

Will LTD premiums be remitted during the elimination period?

Yes     No

If no, what is the ending date for which premiums were remitted?

\_\_\_\_\_ (Day)

\_\_\_\_\_ (Month)

\_\_\_\_\_ (Year)

**Employee**

Employee's Statement

Direct Deposit form with "voided" cheque

Proof of Age (i.e. copy of birth certificate or driver's license)

Canada/Quebec Pension Plan Agreement

Authorization and Consent Form

Authorization to Communicate by Email

Workers' Compensation Agreement if applicable

Copies of WCB (Workers' Compensation Board) correspondence indicating the status of the claim

Medical Evidence

- Attending Physician's Statement
- Physicians' chart notes
- Copies of reports from any medical specialist concerning current disability
- Copies of the results of any investigations concerning current disability

*Employees should be reminded that it is their responsibility to provide the medical evidence to support their entitlement to LTD benefits, therefore, any costs incurred in obtaining this medical evidence is their responsibility. Employees should be advised to provide as much medical information pertaining to the current disability as possible, e.g. specialist reports; physicians' chart notes; test results such as bloodwork, x-rays, EKG, Stress Tests, MRI, etc.*

**Once the employee has completed the required forms and gathered the required information, please ensure that all is submitted to:**

**LTD Administration/ Group Benefit Solutions  
Health Association Nova Scotia  
2 Dartmouth Road  
Bedford, NS B4A 2K7**

*Mark Envelope Private and Confidential – All Forms must be completed in their entirety*

Instructions	
This form is to be fully completed by the employer and should be submitted along with: <ul style="list-style-type: none"> <li>- NSAHO Long Term Disability Checklist</li> <li>- Employee/Member's Statement</li> <li>- Job Description</li> <li>- Completed Employee/Member Forms</li> </ul> Send the completed forms to Health Association Nova Scotia between four and six weeks prior to the benefit start date (end of elimination period)	
Part A – To be completed by the Benefits Administrator or appropriate personnel	
Employer	Division
Location	
Employee Name (Last, First, Initial)	<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.
Date of Birth: (Day)                      (Month)                      (Year)	Social Insurance Number:
Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Number of hours worked last day:
Coverage effective date: (Day)                      (Month)                      (Year)	
Union Group:	
Last Day worked: (Day)                      (Month)                      (Year)	<b>If employee is part time, please indicate the number of weekly guaranteed hours in the space below:</b>  _____ <b>Guaranteed hours per week</b>
Full Time Calculation	Part Time Calculation
1. Hourly Rate at Last Day Worked _____	1. Hourly Rate at Last Day Worked _____
2. Number of Full Time Hours / year _____	2. Number of Part-Time Hours for Six Months Preceding Date Last Worked _____
3. Annual Salary (#1 x #2) _____	3. Salary Over Six Months Preceding Date Last Worked(#1 x #2) _____
4. Monthly Salary (#3 divide by 12) _____	4. Monthly Salary (#3 divide by 6) _____
5. Monthly Benefit (70% of #4) _____	5. Monthly Benefit (70% of #4) _____
Amount of Life Insurance Coverage at Last Day Worked	
Basic \$ _____ AD & D \$ _____ Optional \$ _____ Critical Illness \$ _____	
Has the employee returned to work for full days and full duties for any portion of the elimination period?	
<input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes:                      From:                      To:	
(Day)                      (Month)                      (Year)                      (Day)                      (Month)                      (Year)	

Offsetting Income			
Workers' Compensation (please provide copies of all correspondence concerning WCB for the current period of absence)			
Is the current period of absence due to occupational sickness or accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, has a WCB claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim No:	Benefit \$	
Has a permanent award been made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$	<input type="checkbox"/> Month	<input type="checkbox"/> Lump Sum
Other Income:			
<p><b>The monthly NSAHO LTD benefit is reduced by benefits paid to the employee/member from other sources. Please list any other benefits or income you are aware that your employee/member is claiming or receiving (please provide copies of all correspondence concerning any of these benefits for the current period of absence).</b></p>			
Details	Amount (day/month/year)	Effective Date (day/month/year)	
Employment Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No			
Automobile Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No			
CPP/QPP <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer Retirement/Disability Pension <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer Sick Leave/Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No			
Severance/Retirement Package <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other <input type="checkbox"/> Yes <input type="checkbox"/> No			
Declaration:			
I hereby declare that the above statements and information are true and accurate to the best of my knowledge:			
Name:	Title:	Phone No: (    )	
Signature		(Day)	(Month)    (Year)

**Employee Name:** \_\_\_\_\_

**Occupational Demands:** This section should be completed by the employee's immediate supervisor or by another individual possessing comprehensive knowledge of the occupational demands of the job.

**Musculoskeletal Demands – Use of:**

	Some	Frequent
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/foot	<input type="checkbox"/>	<input type="checkbox"/>

**Cognitive Demands – Use of:**

	Some	Frequent
Sight	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>
Judgement	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Tasks	<input type="checkbox"/>	<input type="checkbox"/>

**Ability to:**

Provide Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Receive Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Interact with Public	<input type="checkbox"/>	<input type="checkbox"/>

**Environment – Exposure to:**

	Some	Frequent
Outdoors	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Heat	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Cold	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Moisture	<input type="checkbox"/>	<input type="checkbox"/>
Dust	<input type="checkbox"/>	<input type="checkbox"/>
Fumes	<input type="checkbox"/>	<input type="checkbox"/>
Gases	<input type="checkbox"/>	<input type="checkbox"/>

**Functional Ability to:**

	Some	Frequent
Twist/turn at waist	<input type="checkbox"/>	<input type="checkbox"/>
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>
Squat below sitting	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>
Balance	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>
Grip	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders or stairs	<input type="checkbox"/>	<input type="checkbox"/>

**Functional Ability to:**
**Carry:**

	Some	Frequent
Over 50 lbs	<input type="checkbox"/>	<input type="checkbox"/>
Over 20 lbs	<input type="checkbox"/>	<input type="checkbox"/>
Over 5 lbs	<input type="checkbox"/>	<input type="checkbox"/>

**Work per day:**

2 - 4 hours	<input type="checkbox"/>	<input type="checkbox"/>
4 - 8 hours	<input type="checkbox"/>	<input type="checkbox"/>
8 - 12 hours	<input type="checkbox"/>	<input type="checkbox"/>
12 - 16 hours	<input type="checkbox"/>	<input type="checkbox"/>
Day Shifts	<input type="checkbox"/>	<input type="checkbox"/>
Night shifts	<input type="checkbox"/>	<input type="checkbox"/>
Work alone	<input type="checkbox"/>	<input type="checkbox"/>
Job rotation	<input type="checkbox"/>	<input type="checkbox"/>

**Health & Safety – Responsible for:**

	Some	Frequent
Safety of others	<input type="checkbox"/>	<input type="checkbox"/>
Machinery operation	<input type="checkbox"/>	<input type="checkbox"/>
Operate Motor Vehicles	<input type="checkbox"/>	<input type="checkbox"/>
Work at heights	<input type="checkbox"/>	<input type="checkbox"/>

**Modified / Alternate Work**

 If the employee could return to work, would modified duties or alternate work be available?  Yes  No

If yes, please provide details

 Has this been discussed with the Employee?  Yes  No

**Declaration (To be signed by the person completing Section B. Please provide a copy of the employee's job description)**

I hereby declare that the above statements concerning the employee's job are true and accurate to the best of my knowledge.

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone No: ( ) \_\_\_\_\_

 \_\_\_\_\_  
Signature

 \_\_\_\_\_  
(Day) (Month) (Year)

**Instructions:** *Please provide as much medical information pertaining to the current disability as possible, e.g. specialist reports; physicians' chart notes; test results such as bloodwork, x-rays, EKG, Stress Tests, MRI, etc.*

- 1) This form is to be fully completed by the Employee and submitted approximately four to six weeks prior to end of elimination period along with:
- |  |  |
|--|--|
| a) Attending Physician's Statement and any supporting medical evidence | d) Direct Deposit Application with voided cheque |
| b) Proof of age (i.e. birth certificate or driver's license)           | e) Copies of WCB correspondence, if applicable   |
| c) CPP Plan Agreement  | f) Authorization and Consent Form                |
- Application forms must be submitted within seven months from the completion of the elimination period (1 year). Claims received after such date are considered late. Late claims are not eligible for retroactive benefit payments, meaning that benefits will only be payable from the date of application.
  - If the claim is submitted more than 1 year late (19 months after completion of the elimination period) the Plan is not liable for benefits and the claim will not be accepted.

- 2) Please note that you are responsible for providing proof that you are entitled to benefits. Therefore:
- a) Please ensure that your treating physician provides copies of all requested file documents with the Attending Physician's Statement(s).  
b) You are responsible for any fees which your doctor may charge to provide this material.

**Identification (Please Print)**

Your Name  Miss     Ms.     Mrs.     Mr.     Dr.  
 (Last) (First) (Initial)

Address  
 (Street & Number)                      (PO Box)                      (City)                      (Province)                      (Postal Code)

Telephone Number (                      )                      Date of Birth  
(Day)                      (Month)                      (Year)

Social Insurance Number

Employer Job Title

**Claim Information**

When did your symptoms first appear?  
(Day)                      (Month)                      (Year)

Have you ever had a similar condition?     Yes     No    If yes, when and describe:

On what date did you last work?  
(Day)                      (Month)                      (Year)

Is disease/injury work related?     Yes     No    If yes, explain:

Describe your disease or injury, including how this prevents you from working:

Claim Information					
Have you done any work for remuneration or on a volunteer basis since your last day worked? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates and list where you worked/volunteered					
Have you returned to work?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes,	<input type="checkbox"/> Full-Time <input type="checkbox"/> Full-Duties	<input type="checkbox"/> Part-Time <input type="checkbox"/> Modified Duties
When do you expect to return to your own job?					
(Day)                                  (Month)                                  (Year)					
Have you discussed modified duties or alternate work with your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:					
Is disability/injury caused by an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Accident:					
(Day)                                  (Month)                                  (Year)					
The accident occurred at: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other - explain					
As a result of this accident, are you taking any action against a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, your lawyer's name: _____ Phone No: (      )					
Address _____ (Street & Number)                                  (PO Box)                                  (City)                                  (Province)                                  (Postal Code)					
Please list the names, addresses and specialties of all doctors consulted as a result of your present condition(s)					
<b>Name</b>	<b>Specialty</b>	<b>Address</b>	<b>First Visit</b>	<b>Last Visit</b>	
			(dd/mm/yy)	(dd/mm/yy)	
			(dd/mm/yy)	(dd/mm/yy)	
			(dd/mm/yy)	(dd/mm/yy)	
			(dd/mm/yy)	(dd/mm/yy)	
Have you been hospitalized as a result of your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Hospital Name		From		To	
(Day)		(Month)	(Year)	(Day)	(Month)          (Year)

**Offsetting Income:** Your monthly NSAHO LTD benefit is reduced by benefits paid to you from other sources. If any of these benefits are paid to you for any or all of the period of time that the NSAHO LTD benefits are paid to you, you are obligated to reimburse the NSAHO LTD Plan. Please list any benefits or income you have applied for or are receiving (please provide copies of all correspondence concerning any of these benefits).

a) **CPP Benefits**  Yes  No Application Date: \_\_\_\_\_  
(Day) (Month) (Year)

Current Status  Pending  Approved  Denied  Appealed **Please provide copies of any correspondence received**

If Approved : Benefit amount per month \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_  
(Day) (Month) (Year)

b) **WCB**  Yes  No Claim No. \_\_\_\_\_ WCB Contact Person: \_\_\_\_\_

Current Status  Pending  Approved  Denied  Appealed **Please provide copies of any correspondence received**

Permanent Award  Yes  No Benefit amount per month \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_  
(Day) (Month) (Year)

Are you receiving any assistance from the WCB Rehabilitation Unit?  Yes  No If yes, explain : \_\_\_\_\_

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount (day/month/year)	Effective Date (day/month/year)
c) <b>Employment Insurance</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
d) <b>Automobile Insurance</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
e) <b>Employer Retirement/Disability Pension</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
f) <b>Employer Sick Leave/Short Term Disability</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
g) <b>Severance/Retirement Package</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
h) <b>Other</b> (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Occupational Demands:** Indicate which of the following activities form part of the job

Musculoskeletal Demands – Use of:			Functional Ability to:		
	Some	Frequent		Some	Frequent
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Twist/turn at waist	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Walk	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Squat below sitting	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>	Stand	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>	Balance	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/foot	<input type="checkbox"/>	<input type="checkbox"/>	Grip	<input type="checkbox"/>	<input type="checkbox"/>
			Climb ladders or stairs	<input type="checkbox"/>	<input type="checkbox"/>
			Grip	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Demands – Use of:			Carry:		
	Some	Frequent	Over 50 lbs	<input type="checkbox"/>	<input type="checkbox"/>
Sight	<input type="checkbox"/>	<input type="checkbox"/>	Over 20 lbs	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	Over 5 lbs	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>			
Concentration	<input type="checkbox"/>	<input type="checkbox"/>			
Memory	<input type="checkbox"/>	<input type="checkbox"/>			
Judgement	<input type="checkbox"/>	<input type="checkbox"/>			
Multiple Tasks	<input type="checkbox"/>	<input type="checkbox"/>			

**Occupational Demands, continued**      **Indicate which of the following activities form part of the job**

<p><b>Ability to:</b></p> <table style="width:100%;"> <tr> <td style="width:30%;"></td> <td style="width:35%; text-align: center;">Some</td> <td style="width:35%; text-align: center;">Frequent</td> </tr> <tr> <td>Provide Supervision</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Receive Supervision</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Interact with Public</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p><b>Environment – Exposure to:</b></p> <table style="width:100%;"> <tr> <td style="width:30%;"></td> <td style="width:35%; text-align: center;">Some</td> <td style="width:35%; text-align: center;">Frequent</td> </tr> <tr> <td>Outdoors</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Excessive Heat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Excessive Cold</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Excessive Moisture</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Dust</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Fumes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Gases</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Some	Frequent	Provide Supervision	<input type="checkbox"/>	<input type="checkbox"/>	Receive Supervision	<input type="checkbox"/>	<input type="checkbox"/>	Interact with Public	<input type="checkbox"/>	<input type="checkbox"/>		Some	Frequent	Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Heat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Cold	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Moisture	<input type="checkbox"/>	<input type="checkbox"/>	Dust	<input type="checkbox"/>	<input type="checkbox"/>	Fumes	<input type="checkbox"/>	<input type="checkbox"/>	Gases	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Work per day:</b></p> <table style="width:100%;"> <tr> <td style="width:60%;"></td> <td style="width:20%; 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Machinery Operation	<input type="checkbox"/>	<input type="checkbox"/>																																																																																
Operate Motor Vehicles	<input type="checkbox"/>	<input type="checkbox"/>																																																																																
Work at Heights	<input type="checkbox"/>	<input type="checkbox"/>																																																																																

**Education & Experience**

Current Position      List the top 5 duties of this position indicating hours per week or percentage of time spent on each.

	Duty	Time / Percentage
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

**Please complete the following section and/or attach a current resume**

Highest Level Attained in High School \_\_\_\_\_

College / University (Degree obtained, if applicable) \_\_\_\_\_

Other \_\_\_\_\_

Courses or training since leaving school

Course	Year
_____	_____
_____	_____
_____	_____



<b>Current Activities</b>			
Activity	Before Illness/Injury	Present	Comments
	Activities Completed and Frequency	Activities Completed and Frequency	Activities Completed and Frequency
Housecleaning			
Childcare			
Meal Preparation			
Grocery Shopping			
Personal Care			
Driving			
Social Activity			
Hobbies			
Exercise Habits			
Pet Care			
Yard Work & Gardening			
Sleep/Rest			
Other			
<b>Are you aware of the EASE program?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, did you participate in the EASE program?</b>
			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional Comments/Information</b>			
<b>Authorization:</b>			
_____		_____	
<b>Claimant's Signature</b>		<b>(DD / MM / YY)</b>	



**Authorization and Consent to  
Limited Collection, Use, and Disclosure of Personal Information**

You are applying for long-term disability benefits through the Health Association Nova Scotia group benefits program and, as part of this process, Health Association Nova Scotia and/or its agents and service providers, including but not limited to Manulife Financial or another insurer, benefits providers or administrators, benefits consultants and medical professionals or rehabilitation service providers may collect, use, disclose and share personal information about you for purposes of assessing eligibility for benefits to which you may be entitled, adjudicating your disability claim, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing and developing a return to work/accommodation program and maintaining an effective claims management process. Your personal information is treated as private and confidential and is used only as reasonably necessary for the uses set out above.

Access to your personal information is limited to only those employees of Health Association Nova Scotia or its agents whose job responsibilities include tasks related to your participation in, or benefits under, the Long-Term Disability Plan or related services. Before your personal information is released to any third party, Health Association Nova Scotia will require that your personal information be safeguarded as reasonably necessary to protect its confidentiality.

By submitting this claim for long-term disability benefits and signing this form;

- You indicate your agreement and consent to these terms;
- You agree that a photocopy or electronic version of the authorization shall be as valid as the original and;

You also authorize and direct the following people or organizations to release such information related to you in their control as is requested by Health Association Nova Scotia and/or its agents, and which is reasonably required for the proper administration of the Long-Term Disability Plan or for the full and proper assessment of your claim for benefits thereunder:

- Any physician, dentist, pharmacist, medical practitioner, or health-related practitioner;
- Any hospital, clinic, pharmacy or other medical or health-related facility;
- Any insurance company, benefits provider or administrator, including those related to any government-sponsored or public benefits; and
- Your employer or former employer(s)

This Authorization and Consent shall remain valid as long as you continue to participate in or receive benefits under the Long-Term Disability Plan or until it is revoked by you in writing.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
(DD/MM/YY)

\_\_\_\_\_  
Signature

- I authorize the EASE consultant and/or EASE program manager to assist me in the LTD application process and inform, Health Association Nova Scotia, my employer, benefits administrator and Manulife Financial of my intent to apply for LTD benefits

\_\_\_\_\_  
Signature



**Long Term Disability  
Authorization to Communicate by Email**

I would like to correspond by email communication with employees of Health Association Nova Scotia and Manulife Financial about my Long Term Disability claim(s). I authorize Health Association Nova Scotia and Manulife Financial to correspond with me at the email address listed below. I understand that any email communication with Health Association Nova Scotia and Manulife Financial may contain my personal information including, but not limited to, medical, employment and financial information.

**I understand email communication is not a secure form of communication and that confidentiality of any email cannot be ensured.**

I understand that this Authorization and Consent shall remain valid as long as I continue to participate in or receive benefits under the Long-Term Disability Plan and that I have the right to revoke it any time.

---

Name (Please Print)

---

(DD/MM/YY)

---

Email Address

---

Signature



Long Term Disability  
Direct Deposit Application

Employee/Member Information		
Employer:	Division:	Location:
Employee (Last, First, Initial)	Social Insurance Number	
<input type="checkbox"/> I authorize Manulife Financial to make direct deposit of my monthly Long Term Disability benefit into my account		
Financial Institution Information		
Name		
Address		
(Postal Code)	(Street)	(City) (Province)
Account Number:	Transit Number:	Bank Code:
Declaration:		
<input type="checkbox"/> I will advise Manulife Financial of any changes in his information and this authorization will remain in effect until I cancel it in writing. I enclose a sample cheque (clearly marked VOID) as a confirmation of my account number, the bank's transit number and the bank number.  If you do not have a chequing account, please send a void counter cheque from your bank.		
_____ Employee Name (First, Last, Initial)		(Please Print)
_____ Employee Signature		(day) (month) (year)



Long Term Disability  
Workers' Compensation Benefits Employee Agreement

Employee/Member Information		
Employer	Division	Location
Employee (Last, First, Initial)		Social Insurance Number
<p>_____ (employee name) being covered under the Nova Scotia Association of Health Organizations (NSAHO) Long Term Disability Plan (claims paying agent being Manulife Financial), affirms that there is a possibility that benefits may be payable under the provision of the Workers' Compensation Plan, on account of the disability commencing on _____(dd/mm/yy) and has made a claim for benefits under the NSAHO LTD Plan.</p> <p><b>Upon the Condition</b> that payments will in no way change, affect, or prejudice any of his/her rights under the Workers' Compensation Plan, and;</p> <p><b>Hereby Agrees</b>, in consideration of such benefit payments on his/her behalf, that is at any later date Workers' Compensation Benefits are paid under the disability section, he/she will repay the claims paying agent for the NSAHO LTD Plan an amount equivalent to the Workers' Compensation Benefit up to a maximum of the aggregate benefit paid under the Long Term Disability Plan.</p> <p><b>And Further Agrees</b> to file his/her claim for disability benefits under the Workers' Compensation Plan immediately.</p> <p><b>And agrees to notify</b> Health Association Nova Scotia or the claims paying agent (Manulife Financial) of the results of his/her claim for Workers' Compensation Benefits.</p>		
Declaration (to be signed by the employee)		
<p>Dated at _____ this _____ day of _____ 20_____</p> <p>_____</p> <p>Employee Signature</p> <p>_____</p> <p>Witness Signature</p>		



Long Term Disability  
Canada /Quebec Pension Plan Employee Agreement

Employee/Member Information		
Employer	Division	Location
Employee (Last, First, Initial)	Social Insurance Number	
<p>Long Term Disability Plan No. 903057 requires me to make application for disability payments under the Canada or Quebec Pension Plan if/when deemed appropriate by the claims adjudicator. The amount of the Long Term Disability Benefits will be reduced each month by any award made by the Canada/Quebec Pension Plan.</p> <p>If, in the opinion of the Claims Adjudicator, I may qualify for either or both of these benefits; I agree that a proper claim, and any necessary appeals, will be made under the Canada/Quebec Pension Plan. Any proof or evidence within my knowledge or possession required by the Canada/Quebec Pension Plan, if not already submitted, shall be submitted immediately.</p> <p>If I fail to apply or appeal, as advised by the Claims Adjudicator I understand that the monthly benefit otherwise payable to me pursuant to this Plan may be reduced by an amount equal to an estimate of the CPP benefits that I would have otherwise received.</p> <p>If my Canada/Quebec Pension Plan claim is approved, I agree to immediately repay to NSAHO the full amount of benefits overpaid by them for any period for which I am paid Canada/Quebec Pension Plan benefits. I agree to send to Health Association Nova Scotia a copy of the Canada/Quebec Pension Plan "Notice of Entitlement".</p>		
<b>Declaration – To be signed by the employee.</b>		
Dated at _____ this _____ day of _____ 20 _____		
_____ Employee Signature		
_____ Witness Signature		

Part A – Patient Identification/Authorization			
Patient's Name	Date of Birth (Day) (Month) (Year)		
Telephone Number	Social Insurance Number		
Address  (Street) (City) (Province) (Postal Code)			
Authorization			
<p>I hereby authorize you to release to Health Association Nova Scotia, its employees and/or agents, including the claims paying agent, such information related to my claim for long term disability benefits as in your control, and as is requested in this form or otherwise.</p>			
<p>_____</p> <p style="text-align: center;">Patient's Signature (Day) (Month) (Year)</p>			
Part B – Attending Physician's Statement			
Dear Doctor:			
<p>1) This form is designed to:</p> <p style="margin-left: 20px;">a) Obtain medical information regarding your patient's functional abilities.</p> <p style="margin-left: 20px;">b) Allow the claims adjudicator to apply your patient's abilities and restrictions to the requirements of his/her own or other occupations</p> <p>2) Your patient is responsible for any charge for the completion of this form.</p> <p>3) Completion of this form "in full" will allow us to determine a reasonable schedule for medical updates. This will reduce the number of future requests to you. If we find it necessary to re-contact you due to incompleteness, your patient may also be responsible for any fee charged for such followup.</p>			
History			
Date symptoms first appeared or accident happened  (Day) (Month) (Year)			
<p>Has patient ceased work due to his/her condition?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, date</p> <p style="text-align: right;">(Day) (Month) (Year)</p>			
Date of first visit for current condition  (Day) (Month) (Year)			
<p>Frequency of visits    <input type="checkbox"/> Weekly    <input type="checkbox"/> Monthly    <input type="checkbox"/> Other _____</p>			
<p>In the 12 months preceding the most recent onset of symptoms, has the patient been treated or diagnosed with the same or a similar condition?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, explain (including dates):</p>			

<b>History, continued</b>			
Have you completed any Workers' Compensation, C/QPP or other insurance medical application as a result of the most recent period of absence? <b>WCB:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>CPP/QPP:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Stated Height	Stated Weight	Current Height	Current Weight
<b>Tests / Referrals</b>			
What Tests have been conducted to confirm the current diagnosis and degree of functioning? Please send copies of all blood work, x-ray and specialist consultations, EKG, Stress Tests, MRI, Etc.			
Test (including clinical tests)	Result		
1.			
2.			
3.			
Are there any further tests/consultations expected/planned before a firm diagnosis can be made or treatment started? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain (including dates):			
	Specialty	Date of visit	
1.			
2.			
3.			
Has the patient ever been hospitalized in relation to the current diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No    Hospital:			
Hospitalized from:		To:	
(Day)	(Month)	(Year)	(Day) (Month) (Year)
Please send copy or relevant hospital discharge summary if / when available			
<b>Diagnosis:</b>			
Primary Diagnosis contributing to current period of work absence:			
Other: (please list all other active, significant medical conditions whether related to the primary condition(s) or not)			



<b>Diagnosis, continued</b>		
If there is a psychiatric component to your patient's condition, please also complete the Psychiatric section. Please do not use subjective descriptions, i.e. pain, etc. If not applicable, please proceed to Treatment Section.		
<b>Psychiatric</b> (To be completed if there is any psychiatric component to your patient's current disabling condition)		
Diagnoses on Axes I - IV (DSM Categories/Terminology Preferred. Terms such as "Anxiety", "Depression", "Stress", require qualification and description)		
Axis I - Major Psychiatric Disorders Currently Being Treated		
1.		
2.		
Axis II – Personality Disorders, Learning Disorders, Mental Retardation		
1.		
2.		
Axis III – Other Medical Conditions		
1.		
2.		
Axis IV – Psychological Factors and Contributing Stressors (indicate if stress is past, with dates, or ongoing)		
1.		
2.		
<b>Treatment</b> (Please indicate which of the following treatments are currently being followed. Indicate active medications including dosage, therapies including frequency, etc.)		
<input type="checkbox"/> Medication	Drug:	Dosage:
	Drug:	Dosage:
	Drug:	Dosage:
<input type="checkbox"/> Physiotherapy	Frequency:	Clinic:
<input type="checkbox"/> Psychotherapy	Frequency:	Psychotherapist:

<b>Treatment, continued</b>		
<small>(Please indicate which of the following treatments are currently being followed. Indicate active medications including dosage, therapies including frequency, etc.)</small>		
<input type="checkbox"/> Specialized Clinic <small>(Eg, pain, back, multi-disciplinary, etc)</small>	Frequency:	Type and Name:
<input type="checkbox"/> Surgery	Type:	Surgeon
<input type="checkbox"/> Other <small>(Please detail)</small>		
Was/Is patient compliant with recommended treatment <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, explain:		
Comments: (future treatment options, expected outcomes, etc.) <small>If additional space is required, please attach additional sheet(s)</small>		
<b>Physician's Assessment of Work Abilities / Restrictions / Medical Findings</b>		
Please base your responses on medical findings - The information on this form will be used to help the employee return to work - The employer may subsequently send you a return to work plan for your comments - If you are unable or uncomfortable answering any specific questions, please indicate in the provided space		
1. Please thoroughly describe your findings and observations of this patient's condition as of the last examination		
2. Please provide your opinion as to the patient's medical restrictions, based on your clinical observations/findings and the results of relevant investigations		

<b>Prognosis</b> (Specific time frames should be used; "indefinite" should not be indicated)					
What is the expected duration of the restrictions noted above?					
<input type="checkbox"/> 1 week <input type="checkbox"/> 2 - 3 weeks <input type="checkbox"/> 4 - 6 weeks <input type="checkbox"/> 7 - 8 weeks <input type="checkbox"/> longer than 8 weeks (please provide details in space provided)					
Have you discussed return to work expectations with your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No     If yes, results:					
<b>Vocational Rehabilitation</b>					
In your opinion, would vocational counselling / rehabilitation be of assistance to your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain					
Do you feel that your patient is a candidate for rehabilitative employment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, when can trial employment commence? <input type="checkbox"/> Part- time _____ Hrs/week <input type="checkbox"/> own job <div style="display: flex; justify-content: space-around; width: 100%;"> <span>(day)</span> <span>(month)</span> <span>(year)</span> </div> <input type="checkbox"/> any job					
<input type="checkbox"/> Full-time _____ Hrs/week <input type="checkbox"/> own job <div style="display: flex; justify-content: space-around; width: 100%;"> <span>(day)</span> <span>(month)</span> <span>(year)</span> </div> <input type="checkbox"/> any job					
Limitations / Restrictions / Modifications:					
<b>Remarks</b> (Provide any additional details which would be helpful for return to work planning)					
Name of Attending Physician (please print)				Specialty:	
Address:				Telephone No: (     )	
(Street)		(City)	(Province)	(Postal Code)	Fax No:
_____ Physician's Signature				_____ (Day)     (Month)     (Year)	