HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Checklist**

**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

**Employee**

❑ Employee's Statement

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

❑ Authorization and Consent Form

❑ Workers' Compensation Agreement if applicable

❑ Direct Deposit form with "voided" cheque

❑ Canada/Quebec Pension Plan Agreement

❑ Authorization to Communicate by Email

❑ 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***

HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Employer Statement**

**Instructions:** This form is to be fully completed by the employer and should be submitted along with:

- NSAHO Long Term Disability Checklist
- Employee/Member's Statement
- Job Description
- Completed Employee/Member Forms

Send the completed forms to Health Association Nova Scotia between four and six weeks prior to the benefit start date (end of elimination period which is 150 consecutive calendar days)

**Part A – To be completed by the Benefits Administrator or appropriate personnel**

| Employer | Division | Location |
|---|---|---|
| Employee Name (Last, First, Initial) | | |

| Date of Birth: (Day) (Month) (Year) | Social Insurance Number: | Status: ❑ Full-Time ❑ Part-Time<br># of hours in Full Time Equivalent for this position: _____ |
|---|---|---|

| Number of hours worked last day: | Coverage effective date: (Day) (Month) (Year) | Union Group: | Has this employee been referred to the **path** program? ❑ Yes ❑ No ❑ Unknown |
|---|---|---|---|

| Supervisor's Name: | Supervisor's Phone No: |
|---|---|
| Last Day worked: (Day) (Month) (Year) | **If employee is part time, please indicate the number of weekly guaranteed hours in the space below:** _____ **Guaranteed hours per week** |

| 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) | _____ |

Please provide the volume of insurance coverage for the following at the employee's last day worked

BASIC LIFE _____ OPTIONAL AD & D _____

OPTIONAL LIFE Employee _____ Spouse _____ Dependent _____

CRITICAL ILLNESS Employee _____ Spouse _____ Dependent _____

Has the employee returned to work for full days and full duties for any portion of the elimination period? ❑ Yes ❑ No

From: (Day) (Month) (Year) To: (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? ❑ Yes ❑ No | | |
| If yes, has a WCB claim been filed? ❑ Yes ❑ No | Claim No: | Benefit $ |
| Has a permanent award been made? ❑ Yes ❑ No | Amount $ ❑ Month | ❑ Lump Sum |

Other Income:

**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).**

| Details | | | Amount (day/month/year) | Effective Date (day/month/year) |
|---|---|---|---|---|
| Employment Insurance | ❑ Yes | ❑ No | | |
| Automobile Insurance | ❑ Yes | ❑ No | | |
| CPP/QPP | ❑ Yes | ❑ No | | |
| Employer Retirement/Disability Pension | ❑ Yes | ❑ No | | |
| Employer Sick Leave/Short Term Disability | ❑ Yes | ❑ No | | |
| Severance/Retirement Package | ❑ Yes | ❑ No | | |
| Other | ❑ Yes | ❑ No | | |

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)

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:** _____

**Part B -- 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 | ☐ | ☐ |
| Shoulder | ☐ | ☐ |
| Elbow | ☐ | ☐ |
| Wrist | ☐ | ☐ |
| Hand | ☐ | ☐ |
| Finger | ☐ | ☐ |
| Back | ☐ | ☐ |
| Hip | ☐ | ☐ |
| Knee | ☐ | ☐ |
| Ankle/foot | ☐ | ☐ |

**Cognitive Demands – Use of:**

| | Some | Frequent |
|---|---|---|
| Sight | ☐ | ☐ |
| Speech | ☐ | ☐ |
| Hearing | ☐ | ☐ |
| Concentration | ☐ | ☐ |
| Memory | ☐ | ☐ |
| Judgement | ☐ | ☐ |
| Multiple Tasks | ☐ | ☐ |

***Ability to:***

| | | |
|---|---|---|
| Provide Supervision | ☐ | ☐ |
| Receive Supervision | ☐ | ☐ |
| Interact with Public | ☐ | ☐ |

**Environment – Exposure to:**

| | Some | Frequent |
|---|---|---|
| Outdoors | ☐ | ☐ |
| Excessive Heat | ☐ | ☐ |
| Excessive Cold | ☐ | ☐ |
| Excessive Moisture | ☐ | ☐ |
| Dust | ☐ | ☐ |
| Fumes | ☐ | ☐ |
| Gases | ☐ | ☐ |

**Functional Ability to:**

| | Some | Frequent |
|---|---|---|
| Twist/turn at waist | ☐ | ☐ |
| Bend at waist | ☐ | ☐ |
| Walk | ☐ | ☐ |
| Sit | ☐ | ☐ |
| Squat below sitting | ☐ | ☐ |
| Stand | ☐ | ☐ |
| Balance | ☐ | ☐ |
| Push/Pull | ☐ | ☐ |
| Reach | ☐ | ☐ |
| Grip | ☐ | ☐ |
| Climb ladders or stairs | ☐ | ☐ |

**Functional Ability to:**

***Carry:***

| | Some | Frequent |
|---|---|---|
| Over 50 lbs | ☐ | ☐ |
| Over 20 lbs | ☐ | ☐ |
| Over 5 lbs | ☐ | ☐ |

***Work per day:***

| | | |
|---|---|---|
| 2 - 4 hours | ☐ | ☐ |
| 4 - 8 hours | ☐ | ☐ |
| 8 - 12 hours | ☐ | ☐ |
| 12 - 16 hours | ☐ | ☐ |
| Day Shifts | ☐ | ☐ |
| Night shifts | ☐ | ☐ |
| Work alone | ☐ | ☐ |
| Job rotation | ☐ | ☐ |

**Health & Safety – Responsible for:**

| | Some | Frequent |
|---|---|---|
| Safety of others | ☐ | ☐ |
| Machinery operation | ☐ | ☐ |
| Operate Motor Vehicles | ☐ | ☐ |
| Work at heights | ☐ | ☐ |

**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

Has this employee been referred to the **path** program? ❑ Yes ❑ No ❑ Unknown

**Declaration** **(To be signed by the person completing Part 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)

HEALTH ASSOCIATION NOVA SCOTIA

Long Term Disability
**Employee/Member Statement**

**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**
   - **b) Proof of age (i.e. birth certificate or driver's license)**
   - **c) CPP Plan Agreement**
   - **d) Direct Deposit Application with voided cheque**
   - **e) Copies of WCB correspondence, if applicable**
   - **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.**

   ***** elimination period is 150 consecutive calendar days***

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:

(Last) (First) (Initial)

Address:

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

Phone No: ( ) Date of Birth: (Day) (Month) (Year)

| SIN: | Employer: | Job Title: |
|---|---|---|
| Supervisor's Name: | Supervisor's Title: | Supervisor's Phone No: |

**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? ❑ Yes ❑ No
If yes, provide dates and list where you worked/volunteered

Have you returned to work? ❑ Yes ❑ No If Yes, ❑ Full-Time ❑ Part-Time ❑ Full-Duties ❑ 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? ❑ Yes ❑ No If yes, provide details:

Is disability/injury caused by an accident? ❑ Yes ❑ No If yes, Date of Accident:
(Day) (Month) (Year)

The accident occurred at: ❑ Home ❑ Work ❑ Motor Vehicle ❑ Other - explain

As a result of this accident, are you taking any action against a third party? ❑ Yes ❑ 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)

| **Name** | **Specialty** | **Address** | **First Visit** | **Last Visit** |
|---|---|---|---|---|
| | | | (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? ❑ Yes ❑ 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 :

| | | | Amount (day/month/year) | Effective Date (day/month/year) |
|---|---|---|---|---|
| c) | **Employment Insurance** | ❑ Yes ❑ No | | |
| d) | **Automobile Insurance** | ❑ Yes ❑ No | | |
| e) | **Employer Retirement/Disability Pension** | ❑ Yes ❑ No | | |
| f) | **Employer Sick Leave/Short Term Disability** | ❑ Yes ❑ No | | |
| g) | **Severance/Retirement Package** | ❑ Yes ❑ No | | |
| h) | **Other** (please describe) | ❑ Yes ❑ No | | |

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

**Musculoskeletal Demands – Use of:**

| | Some | Frequent |
|---|---|---|
| Neck | ☐ | ☐ |
| Shoulder | ☐ | ☐ |
| Elbow | ☐ | ☐ |
| Wrist | ☐ | ☐ |
| Hand | ☐ | ☐ |
| Finger | ☐ | ☐ |
| Back | ☐ | ☐ |
| Hip | ☐ | ☐ |
| Knee | ☐ | ☐ |
| Ankle/foot | ☐ | ☐ |

**Cognitive Demands – Use of:**

| | Some | Frequent |
|---|---|---|
| Sight | ☐ | ☐ |
| Speech | ☐ | ☐ |
| Hearing | ☐ | ☐ |
| Concentration | ☐ | ☐ |
| Memory | ☐ | ☐ |
| Judgement | ☐ | ☐ |
| Multiple Tasks | ☐ | ☐ |

**Functional Ability to:**

| | Some | Frequent |
|---|---|---|
| Twist/turn at waist | ☐ | ☐ |
| Bend at waist | ☐ | ☐ |
| Walk | ☐ | ☐ |
| Sit | ☐ | ☐ |
| Squat below sitting | ☐ | ☐ |
| Stand | ☐ | ☐ |
| Balance | ☐ | ☐ |
| Push/Pull | ☐ | ☐ |
| Reach | ☐ | ☐ |
| Grip | ☐ | ☐ |
| Climb ladders or stairs | ☐ | ☐ |

**Carry:**

| | | |
|---|---|---|
| Over 50 lbs | ☐ | ☐ |
| Over 20 lbs | ☐ | ☐ |
| Over 5 lbs | ☐ | ☐ |

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

**Ability to:**

| | Some | Frequent |
|---|---|---|
| Provide Supervision | ☐ | ☐ |
| Receive Supervision | ☐ | ☐ |
| Interact with Public | ☐ | ☐ |

**Environment – Exposure to:**

| | Some | Frequent |
|---|---|---|
| Outdoors | ☐ | ☐ |
| Excessive Heat | ☐ | ☐ |
| Excessive Cold | ☐ | ☐ |
| Excessive Moisture | ☐ | ☐ |
| Dust | ☐ | ☐ |
| Fumes | ☐ | ☐ |
| Gases | ☐ | ☐ |

**Work per day:**

| | Some | Frequent |
|---|---|---|
| 2 - 4 hours | ☐ | ☐ |
| 4 - 8 hours | ☐ | ☐ |
| 8 - 12 hours | ☐ | ☐ |
| 12 - 16 hours | ☐ | ☐ |
| Day Shifts | ☐ | ☐ |
| Night Shifts | ☐ | ☐ |
| Work Alone | ☐ | ☐ |
| Job Rotation | ☐ | ☐ |

**Health & Safety – Responsible for:**

| | Some | Frequent |
|---|---|---|
| Safety of others | ☐ | ☐ |
| Machinery Operation | ☐ | ☐ |
| Operate Motor Vehicles | ☐ | ☐ |
| Work at Heights | ☐ | ☐ |

**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** |
|---|---|
| | |
| | |
| | |

| **Current Activities** | | | |
|---|---|---|---|
| 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 | | | |

| | |
|---|---|
| **Are you aware of the path program?** ❑ Yes ❑ No<br>**path is an early intervention/support program available to all employees who pay into the HANS LTD plan and have been off work for 21 consecutive calendar days or more due to a non-work related illness or injury (no WCB). Call 1-888-824-3273 for more information** | **If yes, did you participate in the path program?** ❑ Yes ❑ No |

**Additional Comments/Information**

Authorization:

**Claimant's Signature** (DD / MM / YY)

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

I am applying for Long Term Disability ("LTD") benefits through the Health Association Nova Scotia ("HANS") group LTD benefits program administered by The Manufacturers Life Insurance Company ("Manulife").

As part of this process, I authorize HANS and/or its agents or representatives (collectively "HANS Representatives") to share my completed LTD Application Package with Manulife in order for Manulife to assess my eligibility for benefits to which I may be entitled under the group Plan.

I authorize Manulife, its claims service providers, and/or its medical consultants to collect, use, maintain, disclose and share my personal information for purposes of assessing eligibility for benefits to which I may be entitled; adjudicating my disability claim; managing my disability claim; facilitating independent medical or other assessments; auditing; reviewing the benefit Plan as necessary for its proper administration; and assessing and developing a return to work/accommodation program. I understand that my personal information is treated as private and confidential and will only be used as reasonably necessary for the uses set out above.
I further authorize and direct the following people or organizations to release such information related to me that is in their control as may be requested by Manulife, and which is reasonably required for the proper administration of the LTD Plan as well as the proper assessment, investigation, and management of my claim for benefits under the LTD Plan 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
- My employer including any former employer under the HANS member organization participating in the LTD Plan.

To the extent that Manulife collects such information from any of the above people or organizations, I understand that this information will then be included in my claims file.

I expressly authorize Manulife to disclose to HANS Representatives the diagnoses and cause of my disability; medication and treatment information; restrictions, limitations, and functional abilities; assisting in my return-to-work planning; and the management of my claim.

I also expressly authorize Manulife to share my complete LTD claims file to HANS Representatives for the following purposes: in order to make a final determination concerning my eligibility and/or coverage under the Plan; in the event that I appeal a claim decision, to enable HANS Representatives to respond to my appeal; in the event that I may raise a dispute or commence a proceeding concerning my entitlement to benefits under the Plan, to enable HANS Representatives to respond to my dispute or proceeding; and to investigate any alleged/suspected fraud that may arise from my claim. I understand that HANS Representatives will limit access to my personal information to only those employees or its agents whose job responsibilities include tasks related to my participation in, or benefits under, the Long Term Disability Plan or related services. I understand that HANS Representatives will safeguard my personal information to protect its confidentiality and only release it to a third party as reasonably necessary.

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

- I am agreeing and consenting to these terms; and
- I agree that a photocopy or electronic version of the authorization shall be as valid as the original.

This Authorization and Consent shall remain valid as long as I continue to participate in or receive benefits under the Long Term Disability Plan. I may also revoke any of my authorizations at any time by sending written instructions to my Manulife case manager or a HANS Representative.

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

_____ _____
Name (Please Print) Date (MM/DD/YYY)

_____
Signature

HEALTH ASSOCIATION NOVA SCOTIA

**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

HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Direct Deposit Application**

| **Employee/Member Information** | | |
|---|---|---|
| Employer: | Division: | Location: |
| Employee **(Last, First, Initial)** | Social Insurance Number | |

❑ **I authorize Manulife Financial to make direct deposit of my monthly Long Term Disability benefit into my account**

| **Financial Institution Information** | | |
|---|---|---|
| Name | | |
| Address<br>(Street) (City) (Province)<br>(Postal Code) | | |
| Account Number: | Transit Number: | Bank Code: |

**Declaration:**

❑ 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 – Please Print
(First, Last, Initial)

Employee Signature (day) (month) (year)

HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Workers' Compensation Benefits Employee Agreement**

| **Employee/Member Information** | | |
|---|---|---|
| Employer | Division | Location |
| Employee **(Last, First, Initial)** | Social Insurance Number | |

_____ (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.

**Upon the Condition** that payments will in no way change, affect, or prejudice any of his/her rights under the Workers' Compensation Plan, and;

**Hereby Agrees,** 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.

**And Further Agrees** to file his/her claim for disability benefits under the Workers' Compensation Plan immediately.

**And agrees to notify** Health Association Nova Scotia or the claims paying agent (Manulife Financial) of the results of his/her claim for Workers' Compensation Benefits.

**Declaration (to be signed by the employee)**

Dated at _____ this _____ day of _____ 20_____

_____
Employee Signature

_____
Witness Signature

HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Canada /Quebec Pension Plan Employee Agreement**

| **Employee/Member Information** | | |
|---|---|---|
| Employer | Division | Location |
| Employee **(Last, First, Initial)** | Social Insurance Number | |

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.

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.

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**.**

**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".**

**Declaration** – **To be signed by the employee.**

Dated at _____ this _____ day of _____ 20_____

_____
Employee Signature

_____
Witness Signature

HEALTH ASSOCIATION NOVA SCOTIA

**Long Term Disability**
**Attending Physician's Statement**

**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**

**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.**

_____ _____

Patient's Signature (Day) (Month) (Year)

**Part B – Attending Physician's Statement**

Dear Doctor:

1) This form is designed to:
   a) Obtain medical information regarding your patient's functional abilities.
   b) Allow the claims adjudicator to apply your patient's abilities and restrictions to the requirements of his/her own or other occupations
2) Your patient is responsible for any charge for the completion of this form.
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.

**History**

Date symptoms first appeared or accident happened

(Day) (Month) (Year)

Has patient ceased work due to his/her condition? ❑ Yes ❑ No If yes, date

(Day) (Month) (Year)

Date of first visit for current condition

(Day) (Month) (Year)

Frequency of visits ❑ Weekly ❑ Monthly ❑ Other _____

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?

❑ Yes ❑ No If yes, explain (including dates):

**History**, continued

Have you completed any Workers' Compensation, C/QPP or other insurance medical application as a result of the most recent period of absence?

**WCB:** ❑ Yes ❑ No **CPP/QPP:** ❑ Yes ❑ No

| Stated Height | Stated Weight | Current Height | Current Weight |
|---|---|---|---|
| | | | |

**Tests / Referrals**

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? ❑ Yes ❑ 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? ❑ Yes ❑ No Hospital:

Hospitalized from: (Day) (Month) (Year) To: (Day) (Month) (Year)

**Please send copy or relevant hospital discharge summary if / when available**

**Diagnosis:**

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)

**Diagnosis,** continued

**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.**

**Psychiatric**
**(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.

**Treatment**
**(Please indicate which of the following treatments are currently being followed. Indicate active medications including dosage, therapies including frequency, etc.)**

| | | |
|---|---|---|
| ❑ Medication | Drug: | Dosage: |
| | Drug: | Dosage: |
| | Drug: | Dosage: |
| ❑ Physiotherapy | Frequency: | Clinic: |
| ❑ Psychotherapy | Frequency: | Psychotherapist: |

**Treatment**, continued
**(Please indicate which of the following treatments are currently being followed. Indicate active medications including dosage, therapies including frequency, etc.)**

| | | |
|---|---|---|
| ❑ Specialized Clinic (Eg, pain, back, multi-disciplinary, etc) | Frequency: | Type and Name: |
| ❑ Surgery | Type: | Surgeon |
| ❑ Other **(Please detail)** | | |

Was/Is patient compliant with recommended treatment ❑ Yes ❑ No If no, explain:

Comments: (future treatment options, expected outcomes, etc.) **If additional space is required, please attach additional sheet(s)**

**Physician's Assessment of Work Abilities / Restrictions / Medical Findings**

**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

**Prognosis**
**(Specific time frames should be used; "indefinite" should not be indicated)**

What is the expected duration of the restrictions noted above?

❑ 1 week ❑ 2 - 3 weeks ❑ 4 - 6 weeks ❑ 7 - 8 weeks ❑ longer than 8 weeks (please provide details in space provided)

Have you discussed return to work expectations with your patient? ❑ Yes ❑ No If yes, results:

**Vocational Rehabilitation**

In your opinion, would vocational counselling / rehabilitation be of assistance to your patient? ❑ Yes ❑ No
**Please explain**

Do you feel that your patient is a candidate for rehabilitative employment? ❑ Yes ❑ No

If yes, when can trial employment commence? ❑ Part- time _____ _____Hrs/week ❑ own job ❑ any job
(day) (month) (year)

❑ Full-time _____ _____Hrs/week ❑ own job ❑ any job
(day (month) (year)

Limitations / Restrictions / Modifications:

**Remarks**
**(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)