SGEU
WORKING TOGETHER FOR SASKATCHEWAN

Saskatchewan Government and General Employees' Union

www.sgeu.org

1440 Broadway Avenue,
Regina, SK S4P 1E2
(p) 522.8571
1.800.667.5221
(f) 352.1969

1114-22nd Street West,
Saskatoon, SK S7M 0S5
(p) 652.1811
1.800.667.9791
(f) 664.7134

33-11th Street West,
Prince Albert, SK S6V 3A8
(p) 764.5201
1.800.667.9355
(f) 763.4763

**REGINA HEAD OFFICE**

Dear SGEU Member:

Outlined below are the names of the LTD Plan staff members and the roles they perform. All staff members are based in the Regina Office, with the exception of Marilyn Fox-Reid, who is based in the Saskatoon Office.

Shane Osberg, **Director, Disability Management Services**, is the contact person should you have any questions or issues about the LTD Plan and the governing policies and procedures. He can be contacted, toll-free, at 800-667-5221, ext. 204, or direct line no. 306-775-7204, or by e-mail at "sosberg@sgeu.org".

Sharon Flamont, **Administrative Assistant**, is the contact person for handling new claims until adjudication is complete. If you have any questions with regards to the status of your application, she can be contacted, toll-free, at 800-667-5221, ext. 213, or direct line no. 306-775-7213, or by e-mail at "sflamont@sgeu.org".

Lois Burch, **Claimant Advocate**, is the contact person who assists members in filling out long-term disability application forms or assists those members whose claims go into the appeal process. If you have any questions, she can be contacted, toll-free, at 800-667-5221, ext. 216, or direct line no. 306-775-7216, or by e-mail at "lburch@sgeu.org".

Wendy Sherar, **Plan Advocate**, is the contact person who assists members whose claims and/or appeals have been approved and there are questions or issues arising from the decision. Wendy can be contacted, toll-free, at 800-667-5221, ext. 224, or direct line no. 306-775-7224, or by e-mail at "wsherar@sgeu.org".

Myrna Wilgosh, **Advocate,** is the contact person who assists members who require assistance with completion of Canada Pension Plan (CPP) Disability or Pension benefit applications and to assist members whose CPP applications have been denied. Myrna can be contacted, toll-free, at 800-667-5221, ext. 873, or direct line no. 306-775-7873, or by e-mail at "mwilgosh@sgeu.org".

Diana Anderson, Rhonda Ross and Marilyn Fox-Reid are the **Vocational Rehabilitation Counsellors** providing vocational rehabilitation services to members who are able to return to work. If you have any questions or issues, Diana can be contacted, toll-free, at 800-667-5221, ext. 223, or direct line no. 306-775-7223, or by e-mail at "danderson@sgeu.org". Rhonda can be contacted, toll-free, at 800-667-5221, ext. 215, or direct line no. 306-775-7215, or by e-mail at "rross@sgeu.org". Marilyn Fox-Reid can be contacted, toll-free, at 800-667-9791, ext. 379, or direct line no. 306-653-9379, or by e-mail at "mfox-reid@sgeu.org".

Marg Tustin, **Benefits Clerk,** is the contact person should you have any questions regarding the payment or refund of long-term disability premiums, while receiving long-term disability benefits, while on a leave-of-absence or upon retirement. She can be contacted, toll-free, at 800-667-5221, ext. 209, or direct line no. 306-775-7209, or by e-mail at "mtustin@sgeu.org".

The SGEU LTD Plan Staff functions as a team, working to ensure that all Members' long-term disability claims are managed in an effective and timely manner. Therefore, if you contact any staff member, depending on your enquiry, your call will be directed to the appropriate staff member.

# COMPLETION OF THE SGEU LONG TERM DISABILITY CLAIM FORMS

**Check-off List:**

Contact may be made, by the Claimant, the Claimant's Employer or the Claimant's Physician, with any SGEU LTD Plan Advocate for assistance in completion of any of the forms in the LTD application package.

- Claim for Long Term Disability Benefits (Member's Statement) - Complete all areas of the form, both front and back, sign and date.

- Physician's Initial Report Form - Complete Part 2, sign and date and provide to your family doctor and/or specialist to complete Parts 3 to 9. Section 3.3 MUST be completed with year/month/day. Ensure the physician attaches copies of referrals, consultations and diagnostic and test results. It is the Claimant's responsibility to pay for any costs incurred for the completion of this document.

- Job Demands Form - This form is to be completed and signed by your immediate supervisor.

- Electronic Funds Transfer Form - Complete the form and attach a copy of a void cheque.

- Release of Information Form No. 1 - Complete this form to provide information on group life insurance.

- Release of Information Form No. 2 - Complete this form for release of your LTD Claim information to a person that can speak on your behalf.

- Release of Information Form No. 3 - Complete this form to enable SGEU LTD Plan and the Plan's Medical Adjudicator to acquire medical information pertinent to your long-term disability claim.

- Release of Information Form No. 4 - Complete this form to provide information on pension contributions.

- Release of Information Form No. 5 - Complete this form for release of your W.C.B. Claim information.

over …

- ❑ Release of Information Form No. 7 – Complete this form for release of your employment information. No medical information will be provided to your employer.

- ❑ Release of Information No. 8 – Complete this form for release of your SGI Claim information.

Note:

- A non-certified copy of your birth certificate or a copy of a valid driver's licence or passport is required and should accompany your claim application.

- Upon request from the LTD Plan or the Medical Adjudicator, you will be required to apply for Canada Pension Plan disability benefits. The Plan's Medical Adjudicator will provide information on the process if you are accepted to the Plan. An SGEU LTD Advocate can also assist with completion of the application.

- If your disability is a result of a workplace injury, you MUST apply for WCB benefits, if you have not already done so. If you have already made application, submit all WCB documentation with your LTD application.

- If your disability is a result of a motor vehicle accident, you MUST apply for SGI benefits, if you have not already done so. If you have already made application, submit all SGI documentation with your LTD application.

- You may be eligible for Employment Insurance sick benefits. Contact your nearest Social Development Canada office to make application for this benefit, or visit the website at "www.sdc.gc.ca".

- You MUST use up all of your sick leave hours prior to receiving any Long Term Disability Plan income entitlements.

- You are NOT REQUIRED to use up annual vacation prior to receiving Long Term Disability Plan income entitlements.

Saskatchewan Government and General Employees' Union

SGEU
WORKING TOGETHER FOR SASKATCHEWAN

www.sgeu.org

1440 Broadway Avenue,
Regina, SK S4P 1E2
(p) 522.8571
1.800.667.5221
(f) 352.1969

1114-22nd Street West,
Saskatoon, SK S7M 0S5
(p) 652.1811
1.800.667.9791
(f) 664.7134

33-11th Street West,
Prince Albert, SK S6V 3A8
(p) 764.5201
1.800.667.9355
(f) 763.4763

**REGINA HEAD OFFICE**

Dear Member:

This letter addresses very serious matters.

1. **DO NOT RESIGN -** Some members have been tempted or persuaded to resign from their jobs after having their long-term disability claim approved. Do not make any decision without the advice of your Union representative or the SGEU LTD Claimant Advocate. If you resign:

- you are giving up your job;
- your employer has no further obligation to you;
- SGEU Long-Term Disability Plan has no further obligation to you; and
- all benefits, including pension contributions, will cease at the time of your resignation.

2. Medical evidence regarding your claim.

- Copies of all relevant medical information, such as physician's clinical notes, diagnostic test results and referrals and consultation letters, should be submitted with your application
- It is your responsibility to provide medical information required for the adjudication of your claim. All costs incurred in obtaining this information are your responsibility.

3. Long-Term Disability premiums payments, extended health and dental benefits and life insurance queries (options in your Collective Bargaining Agreement language) should be directed to your employer's Human Resources/Payroll Department.

4. Elimination Period - To qualify for long-term disability benefits, you must be off work for 119 consecutive days, or 85 cumulative days within the previous twelve (12) months from the date you left work. If you attempt a return-to-work, after the date you initially left work, the hours you have worked will be added to your elimination period. If you need further information on the "cumulative" or "return-to-work" elimination period, call an LTD Plan Advocate in the Regina Office.

If you have any questions regarding the SGEU LTD Plan, contact a Plan Advocate at 306-522-8571 or, toll-free, at 800-667-5221 or visit the SGEU website at "www.sgeu.org".

Sincerely,

SGEU LTD Plan

03/13

SGEU LTD Plan
1440 Broadway Avenue
Regina, Sask. S4P 1E2
Local: 522-8571
Toll Free: 1-800-667-5221

# Claim for Long-Term Disability Benefits

## Part 1 – MEMBER'S STATEMENT

**MEMBER IDENTIFICATION (Please Print)**

☐ Mr. ☐ Mrs. ☐ Ms. Last Name: First Name: Middle Initial:

Address: City/Town: Province: Postal Code:

| Social Insurance Number: | Date of Birth: | Telephone No: ( ) |
|---|---|---|

Employer: Department:

Job Title: Shiftworker: ☐ Yes ☐ No

**CLAIM INFORMATION**

Describe your present condition, its cause and history to date. If injured, indicate the nature of the accident. (Attach separate sheet, if necessary.)

When did your health first become affected? Date

From what date has your condition prevented you from working? Date

Were you hospitalized for this condition? ☐ Yes ☐ No If "YES", provide the date(s) and hospital name(s).

When do you expect to be able to return to: a) your own occupation? Date b) any occupation? Date

Indicate if you have tried to return to work? ☐ Full time ☐ Part-time ☐ Usual job ☐ New Job/Duties

Give dates: From: Date To: Date

**SUMMARY OF EDUCATION, TRAINING, EXPERIENCE**

ATTACH RESUME OR COMPLETE THE FOLLOWING:

| Highest Education Completed | Location | Level Obtained | Year | Area of Study & Years Completed |
|---|---|---|---|---|
| | | | | |

WORK EXPERIENCE (Begin with most recent and add separate pages, if necessary.)

| Duration of Employment | | Employer | Job Title |
|---|---|---|---|
| From | To | | |
| | | | |
| | | | |
| | | | |
| | | | |

List all specialized training not included above. (Attach separate paper or resume, if necessary.)

## DISABILITY INCOME

Please provide the details of any benefits which you are, or will be, claiming from other sources with respect to your disability. Enclose copies of all correspondence and documents from these insurers, including any notices of entitlements (acceptance of your claim), letters denying your claim and notices of appeal. Complete **ALL** that apply.

☐ Canada Pension Plan Disability Benefits — Claim No:

Amount of Benefit: — Paid From/To: Dates

Date Accepted/Denied: Date — Date Appealed: Date

☐ WCB Disability Benefits — Claim No:

Amount of Benefit: — Paid From/To: Dates

Date Accepted/Denied: Date — Date Appealed: Date

☐ SGI — Claim No:

Amount of Benefit: — Paid From/To: Dates

Date Accepted/Denied: Date — Date Appealed: Date

☐ Other Disability Benefit(s) — Insurer's Name:

Amount of Benefit: — Claim No: — Paid From/To: Dates

Date Applied: Date — Date Accepted/Denied: Date — Date Appealed: Date

Insurer's Address:

## AUTHORIZATION

I hereby certify that the information provided herein is true, accurate and complete. I authorize any required payroll deductions and the use of my Social Insurance Number (if given as employee identification number) for administration of my benefits. I hereby authorize the use of all information in my file for the purposes of adjudication and administration of my long-term disability claim, as per the SGEU LTD Plan Text. A photocopy of this authorization shall be as valid as the original.

Dated at _____ this _____ Day of _____ Month _____ Year

_____

Signature of Claimant

_____

_____

_____

_____

Address of Claimant

## PHYSICIAN'S INITIAL REPORT FORM

### Part 2 – Identification and Authorization *Part 2 to be completed by Member.*

| | | |
|---|---|---|
| Name and Address of Insurer:<br>**SGEU Long Term Disability Plan** | Address of Insurer:<br>**1440 Broadway Avenue, Regina, SK S4P 1E2** | |
| Name of the Plan's Medical Adjudicator*<br>**Manulife Financial**<br>*Subject to appointment from time to time. | | |
| Last Name of Member First Name Initial | Member's DOB (y/m/d) | Member's S.I.N. |
| I hereby authorize the release to my insurer and to my policy holder of any information in respect to the settlement of this claim.<br>Member's Signature Date (y/m/d) | | |

### Part 3 – History and Findings

To provide further information on any physical disability or a mental health or emotional disability, complete the applicable portions of this form and attach a narrative statement.

| | |
|---|---|
| 3.1 Mechanism of injury or onset of illness | |
| 3.2 To the best of my knowledge, the illness started or the injury happened on (y/m/d). | 3.3 To the best of my knowledge, the Member has been unable to work as a result of the disability from (y/m/d). |
| 3.4 Date of first examination / treatment for the present condition (y/m/d). | 3.5 Dates of hospitalization (y/m/d)<br>From To<br>Name of hospital |
| 3.6 Physical findings | |
| 3.7 Diagnostic tests ordered | 3.8 Findings from diagnostic tests (Attach copies of all results.) |

### Part 4 – Diagnosis

| | |
|---|---|
| 4.1 Diagnosis of Physical Illness or Injury | 4.2 Diagnosis of Mental or Emotional Illness<br>Is This A Workplace Issue? ☐ Yes ☐ No |

## Part 5 – Management Plan

5.1

[ ] Active treatment is required - Next Appointment Scheduled (y/m/d) _____

[ ] No Active treatment is required

5.2 Treatment initiated: (specify in each case)

Medications _____

Exercise/Therapy _____

Education/Other Treatment _____

The medication(s) might impair safety in the workplace for the Member or for others as follows:

5.3 Referred for assessment/treatment to (specify name and date):

[ ] Medical/Surgical Specialist _____

[ ] Psychiatrist _____

[ ] Counsellor _____

[ ] Physical Therapist _____

[ ] Other Therapist _____

[ ] Chiropractor _____

[ ] Other Referral _____

5.4 To the best of my knowledge, the Member is prepared to follow the above management plan.

[ ] Yes [ ] No (If no, explain why not.)

## Part 6 – Activity Level and Prognosis

6.1 The Member is currently working? Yes **[ ]** No **[ ]** Participating in activities of daily living? Yes **[ ]** No **[ ]**

6.2 The Member is unable to participate in normal activities, including work, because of limitations in one or more of the following areas (provide explanation):

[ ] Standing _____

[ ] Sitting _____

[ ] Lifting _____

[ ] Turning _____

[ ] Mental Function _____

[ ] Allergies _____

[ ] Work Environment _____

[ ] Other _____

6.3 The disability may affect activity for: Over 119 calendar days **[ ]** Unknown **[ ]**

| 6.4 Permanent scarring or disfigurement Yes **[ ]** No **[ ]** | 6.5 Permanent functional disability is possible Yes **[ ]** No **[ ]** |
|---|---|

## Part 7 – Past History and Other Conditions

| |
|---|
| 7.1 Other factors that might effect the duration of the current disability are:<br>Addictions **[ ]** Pre-existing medical conditions **[ ]** Environmental **[ ]** Physical Fitness **[ ]** Family **[ ]** Dietary **[ ]**<br>Other medical conditions **[ ]** Employment **[ ]** Psychosocial **[ ]** Other **[ ]**<br>The specifics of the above indicated factors are: |
| 7.2 The Member previously had the same or similar condition as follows: |
| 7.3 The following remarks might be helpful or important to explain the Member's recovery and return to work: |

## Part 8 – Rehabilitation

| | For Own Occupation | For Any Other Occupation |
|---|---|---|
| 8.1 Is Member a suitable candidate for trial employment? | Yes **[ ]** No **[ ]** | Yes **[ ]** No **[ ]** |
| 8.2 If "YES", when could trial employment commence? | | |
| **[ ]** Part–time | yy/mm/dd | yy/mm/dd |
| **[ ]** Full–time | yy/mm/dd | yy/mm/dd |
| 8.3 If "NO", provide explanation: | | |
| 8.4 Would vocational rehabilitation be recommended: Yes **[ ]** No **[ ]** | | |

## Part 9 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)

| Last Name First Name Initial | | Practitioner/Payee Number |
|---|---|---|
| Street Address | Phone No. | Fax No. |
| Town/City | Province | Postal Code |
| Signature | | Date yy/mm/dd |

**NOTE: It is the Claimant's responsibility to pay for any costs incurred for the completion of this document.**

SGEU LTD Plan
1440 Broadway Avenue
Regina, Sask. S4P 1E2
Local: 522-8571
Toll Free: 1-800-667-5221

# JOB DEMANDS

Job Title (Please Print): _____

Department (Please Print): _____

| JOB DEMANDS | | Employer's Statement | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | WEIGHT | | FREQUENCY | | | | |
| | | Max | Usual | Not performed | Performed not daily | <1 hour daily | 1-3 hours daily | Maximum ability |
| **STRENGTH** Lifting-including pushing and pulling effort while stationary | | | | | | | | |
| Carrying-including pushing and pulling effort while walking | | | | | | | | |
| Fingering | Right | | | | | | | |
| | Left | | | | | | | |
| Handling | Right | | | | | | | |
| | Left | | | | | | | |
| Reaching | Below Shoulder | | | | | | | |
| | Above Shoulder | | | | | | | |
| Gripping | Minimum | | | | | | | |
| | Moderate | | | | | | | |
| | Maximum | | | | | | | |
| **MOBILITY** Throwing | | | | | | | | |
| Sitting | | | | | | | | |
| Standing | | | | | | | | |
| Walking | | | | | | | | |
| Running | | | | | | | | |
| Climbing | | | | | | | | |
| Stooping | | | | | | | | |
| Crouching | | | | | | | | |
| Kneeling | | | | | | | | |
| Crawling | | | | | | | | |
| Twisting | | | | | | | | |
| **SENSORY / PERCEPTUAL** | Conversation | | | | | | | |
| Hearing | Other sounds | | | | | | | |
| Vision | Far | | | | | | | |
| | Near | | | | | | | |
| | Colour | | | | | | | |
| | Depth | | | | | | | |
| Reading | | | | | | | | |
| Writing | | | | | | | | |
| Speech | | | | | | | | |

| JOB DEMANDS | Employer's Statement | | | | | | |
|---|---|---|---|---|---|---|---|
| | WEIGHT | | FREQUENCY | | | | |
| | Max | Usual | Not performed | Performed not daily | <1 hour daily | 1-3 hours daily | Maximum ability |
| **ENVIRONMENT** Inside Work | | | | | | | |
| Hot | | | | | | | |
| Cold | | | | | | | |
| Humid | | | | | | | |
| Dry | | | | | | | |
| Dust | | | | | | | |
| Vapour, Fumes | | | | | | | |
| **HAZARDS** Moving Objects | | | | | | | |
| Hazardous machines | | | | | | | |
| Electrical hazards | | | | | | | |
| Sharp tools, etc. | | | | | | | |
| Radiant energy | | | | | | | |
| Slippery floors | | | | | | | |
| Cluttered worksite | | | | | | | |
| **JOB STRESSORS / CONDITIONS OF WORK** Travel | | | | | | | |
| Working on call | | | | | | | |
| Working overtime | | | | | | | |
| Shift work | | | | | | | |
| Equipment/machinery/vehicle operation | | | | | | | |
| Deadlines to be met | | | | | | | |
| Work with public | | | | | | | |
| Speak with public | | | | | | | |
| Speak to groups | | | | | | | |
| Work independently | | | | | | | |
| Work in isolation | | | | | | | |
| Physical mobility in work | | | | | | | |
| Depend on others for information | | | | | | | |
| Boredom | | | | | | | |
| Decision making | | | | | | | |
| Other | | | | | | | |

Member's Comments:

Member's Signature:

Supervisor's Name: _____ Official Title: _____

Supervisor's Signature: _____ Date: _____

# Electronic Funds Transfer Form

- ☐ New Enrolment
- ☐ Advice of Change

## Plan Member Information - Please Print

| Plan Number | Identification Number | Plan Name |
|---|---|---|
| 1151 | | SGEU Long Term Disability Plan |

Plan Member (First Name) Initial Plan Member (Last Name)

Street Address City or Town Province Postal Code

Home Telephone Number: ( ) Business Telephone Number: ( )

## Banking Information - Please Print

**Instructions:**

Please have your bank branch office verify the bank section before returning to the company address. If possible, attach a voided cheque.

Advise us promptly of any change of bank, branch or account number.

This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account.

All information submitted will be treated as private and confidential

Name of Bank / Financial Institution

Street Address City or Town Province

| Postal Code | Institution Number | Transit Number | Account Number |
|---|---|---|---|
| | 0 | | |

## Authorization

I hereby authorize Manulife Financial to use the Electronic Funds Transfer system until written instructions are issued cancelling this agreement.

Plan Member Signature Date (D/M/Y)

# RELEASE OF INFORMATION

## FORM NO. 1

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REGARDING MY GROUP LIFE INSURANCE PLAN AND EXTENDED HEALTH AND DENTAL INSURERS, REQUESTED BY THE LIFE AND EXTENDED HEALTH AND DENTAL INSURANCE COMPANY OR ANY SUCCESSOR ADMINISTERING SAID GROUP LIFE PLAN.

_____
MEMBER'S NAME

_____
SIGNATURE

_____
DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 2

I HEREBY AUTHORIZE AND DIRECT THE SGEU LONG TERM DISABILITY PLAN AND/OR THE PLAN'S MEDICAL ADJUDICATOR TO RELEASE TO:

NAME (SPOUSE/FAMILY/OTHER) TELEPHONE NUMBER

_____ _____

_____ _____

_____ _____

ANY SGEU LTD PLAN BENEFIT OR MEDICAL INFORMATION WHICH MAY HAVE BEEN ACQUIRED DURING THE COURSE OF MY LONG TERM DISABILITY PLAN CLAIM.

_____
MEMBER'S NAME

_____
SIGNATURE

_____
DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 3

I HEREBY AUTHORIZE AND DIRECT ANY PHYSICIAN, SURGEON, HOSPITAL AND/OR ANY OTHER HEALTH CARE PROVIDER, WHO HAS EXAMINED OR TREATED ME, TO RELEASE TO THE SGEU LONG TERM DISABILITY PLAN AND/OR THE PLAN'S MEDICAL ADJUDICATOR ANY INFORMATION WHICH MAY HAVE BEEN ACQUIRED IN THE COURSE OF SUCH EXAMINATION OR TREATMENT.

I UNDERSTAND THAT THIS INFORMATION IS TO BE USED FOR THE SOLE PURPOSE OF MY APPLICATION FOR AND RECEIPT OF SGEU LONG TERM DISABILITY PLAN BENEFITS.

_____
MEMBER'S NAME

_____
SIGNATURE

_____
DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 4

I HEREBY AUTHORIZE AND DIRECT THE SGEU LONG TERM DISABILITY PLAN AND/OR THE PLAN'S MEDICAL ADJUDICATOR TO OBTAIN ANY INFORMATION REGARDING MY PENSION CONTRIBUTIONS FOR THE PURPOSES OF ADMINISTERING MY CLAIM.

_____

MEMBER'S NAME

_____

SIGNATURE

_____

DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 5

I HEREBY AUTHORIZE AND DIRECT THE SGEU LONG TERM DISABILITY PLAN TO OBTAIN ANY INFORMATION, FROM SASKATCHEWAN WORKERS' COMPENSATION BOARD, REGARDING MY WORKERS' COMPENSATION BOARD APPLICATION FOR ENTITLEMENT AND THE DECISION ON SUCH APPLICATION.

_____

MEMBER'S NAME

_____

SIGNATURE

_____

DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

**RELEASE OF INFORMATION**

**FORM NO. 6**

I HEREBY AUTHORIZE AND DIRECT THE SGEU LONG TERM DISABILITY PLAN AND/OR THE PLAN'S MEDICAL ADJUDICATOR TO RELEASE ANY INFORMATION TO MY ADVOCATE _____, TO BE USED FOR THE SOLE PURPOSE OF ADVOCATING ON MY BEHALF THROUGH THE APPEAL PROCESS OF THE SGEU LONG TERM DISABILITY PLAN:

_____
MEMBER'S NAME

_____
SIGNATURE

_____
DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 7

I HEREBY AUTHORIZE THE RELEASE OF ANY EMPLOYMENT INFORMATION BETWEEN THE SGEU LTD PLAN AND MY EMPLOYER:

_____

THAT IS REQUIRED FOR THE PURPOSES OF ADMINISTERING THE BASIC INFORMATION FORM.

_____
MEMBER'S NAME

_____
SIGNATURE

_____
DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.

# RELEASE OF INFORMATION

## FORM NO. 8

I HEREBY AUTHORIZE AND DIRECT THE SGEU LONG TERM DISABILITY PLAN TO OBTAIN ANY INFORMATION, FROM SASKATCHEWAN GOVERNMENT INSURANCE, REGARDING MY SASKATCHEWAN GOVERNMENT INSURANCE APPLICATION FOR ENTITLEMENT AND THE DECISION ON SUCH APPLICATION.

_____

MEMBER'S NAME

_____

SIGNATURE

_____

DATE

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.