Important Information for Claimants

You must be an active **member** of SGEU at the time of making a claim for LTD Benefits and to remain covered once on an approved claim. **Do not resign from your employment** during the eligibility period or while on a claim.

You must submit your LTD application within one-year from your date of disability. It is recommended that you **submit your application within the 119-day elimination period** to avoid delays in your receipt of benefits.

Accrued sick leave with your employer must be depleted prior to receiving LTD Plan benefits, even if your claim is approved. You are not required to use your accrued vacation.

Your LTD Premiums must be paid and up to date to be eligible for a claim. If you have questions, contact LTD@SGEU.ORG or 306-775-7876 (1-800-667-5221).

The SGEU Long Term Disability Claim Forms

The LTD package includes:

- Long Term Disability Plan Guide
- Disability Management Staff Support
- Member's Statement – Claim for SGEU LTD Benefits
- Physician's Initial Report Form
- Job Demands Information
- Blue Cross Direct Deposit Request
- 9 separate release forms

Completed claim documents can be submitted by:

Mail:	**Fax:**
Pre-Paid Envelope Provided Attention: SGEU LTD Department Saskatchewan Government and General Employees' Union 1011 Devonshire Drive North Regina, SK. S4X 2X4	1-306-775-5775 **Email:** LTD@SGEU.ORG

Date: 2023

SGEU Working Together for Saskatchewan

Checklist for Claim Forms

Member's Statement Long Term Disability Benefits (Member's Statement)

- ❑ Complete all areas of the form, both front and back, sign and date.
- ❑ Include ID with Date of Birth (non-certified copy of birth certificate or copy of valid driver's licence or passport)
- ❑ Electronic Funds Transfer Form - Complete the form and attach a copy of a void cheque or a bank authorization form.
- ❑ Nine (9) Releases for Information (each release is a legal requirement for SGEU LTD to be able to gather and communicate with stakeholders regarding relevant information for your claim and benefits payments. See forms for further details.

Job Demands Form

- ❑ This form is to be completed and signed by your immediate supervisor/employer/delegate.

Physician's Initial Report Form

- ❑ **Complete Part 1**, sign and date and provide to your family doctor and/or specialist to complete Parts 2 to 8.
- ❑ Ensure the **physician attaches copies** of referrals, consultations, diagnostics and test results.
- ❑ ***It is the Claimant's responsibility to pay for any costs incurred for the completion of this document.***

If your disability is a result of:

- A workplace injury you must apply for WCB benefits and include all WCB documentation and claim information with your LTD Claim submission.
- A motor vehicle accident you must apply for SGI benefits and include all SGI documentation an claim information with your LTD claim submission.

Advocates are available at 306-775-7876 or 1-800-667-5221 if you have questions or require assistance in completing your LTD Claim.

Date: 2023

SGEU WORKING TOGETHER FOR SASKATCHEWAN

Disability Management Services Staff

The following roles exist within Disability Management Services of SGEU to support the member's Long-Term Disability (LTD) claim experience and the SGEU LTD Plan.

- The **Director, Disability Management Services** provides direction and leadership regarding the LTD Plan in accordance with the governing bodies, policies, and procedures.

- **Administrative Assistants** handle the collection and preparation of claims for adjudication, collection and inquiries regarding LTD premiums and rebates, and provide support for the governing bodies in meeting their documentation and reporting needs.

- The **Claimant Advocate(s)** assist members in completing their LTD applications and those members that proceed through the appeal process as needed.

- The **Plan Advocate** assists employers and members whose claims have been approved and have questions pertaining to the entitlements and provisions available under the LTD Plan.

- The **CPP Advocate** assists members who require support in applying for the Canada Pension Plan (CPP) Disability or Retirement benefit and is a resource to members who may have had their CPP application denied.

- **Vocational Rehabilitation Counsellors** provide vocational rehabilitation services to members who are returning to work or requiring support for accommodations, retraining, or job placements.

To reach a staff member of Disability Management Services contact the Regina SGEU office @ **1-306-775-7876** or **1-800-667-5221** or email **LTD@SGEU.ORG** and ask for appropriate support.

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

To complete your claim submission:

- Complete the Plan Member's Statement
- Complete Part 1 on the Physician's Initial Report and have your healthcare provider complete the remaining parts
- Have your employer complete the Plan Member's Job Demands form
- Submit the Plan Member's Statement, Physician's Initial Report, Release Forms, and Banking Information to the SGEU LTD Plan

☐ I certify the information given on this claim form is true, correct, and complete to the best of my knowledge.

Part 1 – Member Information

MEMBER IDENTIFICATION (Please Print)

Last Name:	**First Name:**	**Middle Initial:**

Gender: Female ☐ Male ☐ Other ☐	**Date of Birth (mm/dd/yy):** Include government issued Identification (i.e Driver's License or Passport)	**Social Insurance Number:**

Address:	**City/Town:**	**Province:**	**Postal Code:**

Cell:	**Home:**	**Home Email Address:**

Employer:	**Job Title:**

Part 2 – Claim Information

When was your last physical day at the workplace: (mm/dd/yy) _____
(if date unknown, contact your employer)
IMPORTANT: do not include sick leave or vacation days taken after this date

Indicate if you have tried to return to work? ☐ No ☐ Yes

If Yes, Give dates: From: _____ (mm/dd/yy) To: _____ (mm/dd/yy)

I returned to (select all that apply): ☐ Regular duties and hours ☐ Modified duties ☐ Modified hours ☐ New Job

If no, when to you expect to return (if known): _____ (mm/dd/yy)

Are there any aspects of your job that you might be able to do, even on a reduced basis? If yes, describe:

During your absence, have you performed any other work? ☐ No ☐ Yes. If yes, describe:

What is/was the medical condition causing your absence from work? Describe your present condition, the cause (if known), and the history to date. (Attach additional if more space is needed)

☐ I have attached additional information.

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Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

Is your condition work-related? ☐ No ☐ Yes. If yes, have you submitted a WCB claim? ☐ No ☐ Yes
If yes, provide your Workers' Compensation claim number:

Is your condition the result of a motor vehicle accident (MVA)? ☐ No ☐ Yes. If yes, have you submitted an SGI (MVA) claim? ☐ No ☐ Yes **If yes,** when and where did the accident occur (mm/dd/yy):
Provide details about the accident:

Part 3 – Treatment Information

Were you admitted to a hospital? ☐ No ☐ Yes. If yes, provide the date(s) and hospital name(s).

Hospital name:

Date admitted (mm/dd/yy):	**Date discharged (mm/dd/yy)**	**Or** ☐ Still hospitalized

Have you had surgery since being off work, or is surgery planned: ☐ No ☐ Yes.

Date of surgery (mm/dd/yy):	**Type of surgery:**

Other treatment (crutches, physiotherapy, medication, counseling.):

Primary healthcare provider

Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):

Do you have other healthcare providers related to this claim? ☐ No ☐ Yes. **If yes,** please provide details.

Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):
Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):

If more space is needed, please attach. ☐ I have attached additional information.

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LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

Part 4 – Education, Training, Experience

ATTACH RESUME OR COMPLETE THE FOLLOWING

EDUCATION

Highest level of education completed:

School Name	Location: Level Obtained:	Year (yyyy):	Area of Study & Years Completed

WORK EXPERIENCE

Duration of Employment		Employer	Job Title
From (mm/dd/yy)	To (mm/dd/yy)		

Please attach a separate sheet if additional space is required

Part 5 – Disability Income

Please answer no or yes to each question below and provide details and additional documents as appropriate:

1. Are you receiving **Canada Pension Plan (CPP)** ***Retirement*** Income? ☐No ☐Yes
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)
☐ provide a copy of your approval letter.

2. Have you applied for CPP *Retirement* Income, but have not yet been accepted? ☐No ☐Yes

3. Are you receiving **Canada Pension Plan (CPP)** ***Disability*** Income? ☐No ☐Yes
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)
☐ provide a copy of your approval letter.

4. Have you applied for CPP *Disability* Income, but have not been accepted? ☐No ☐Yes
If yes, please indicate: ☐ My claim decision is pending, **or** ☐ My claim has been declined*

Date of Decline: _____ (mm/dd/yy) Date of Appeal:_____ (mm/dd/yy)

5. Are you receiving **Workers Compensation Board** ***(WCB)*** or **Saskatchewan Government Insurance** ***(SGI)*** Income?
☐ No ☐Yes (WCB) ☐Yes (SGI)
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)

6. Have you applied for WCB or SGI Income benefits, but have not been accepted?
☐No ☐Yes (WCB) ☐Yes (SGI)
If yes, please indicate: ☐ My claim decision is pending, or ☐ My claim has been declined

Date of Decline: _____ (mm/dd/yy) Date of Appeal:_____ (mm/dd/yy)

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LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits Plan Member's Statement

7. Are you receiving **any other income**? ☐No ☐Yes

If yes: Source (eg. Other Insurer, Other employer, Self-employed, Retirement) _____

Monthly Amount: _____ Dates of Payments: From _____ (mm/dd/yy)

Part 6 – Authorization, Declaration, and Reimbursement Agreement

I understand and agree that:

- I may be required to apply for other disability/pension benefits (WCB/SGI/CPP Disability/Pension) that I may be entitled to receive because of my disability and that I may be asked by SGEU LTD or its third-party medical adjudicator to reapply or appeal decisions refusing my application(s) if considered applicable.
- During the time it takes for my application for these other benefits to be accepted, or my entitlement to any other reportable income to be reviewed, SGEU LTD through it's third-party medical adjudicator, may continue paying me amounts equivalent to the disability benefits payments under the SGEU Plan Text. The terms "other benefits" and "other reportable income" refer to any of the types of disability benefits and other income mentioned under the SGEU LTD Plan Article 8.3 "Income From Other Sources".
- If I am entitled to receive any other disability benefits or other reportable income, this may result in an overpayment that I will be required to pay back to the SGEU LTD Plan.
- SGEU LTD may reduce my disability benefit payments by the amount of other disability/pension benefits or other reportable income that I receive or become entitled to.

I agree to:

- Notify SGEU LTD or its third-party medical adjudicator within 15 days of receipt of any other reportable income (including any other disability benefit/pension payments) or any other reportable Income.
- Repay SGEU LTD within the time frame SGEU LTD or its third-party medical adjudicator advises me of after I am notified of the overpayment or within a longer period if SGEU LTD agrees in writing. I understand that if the overpayment is not reported when due, SGEU LTD and its third-party medical adjudicator may take all necessary steps to recover the overpayment, including withholding the payment, or recovering the overpayment from any benefits under the SGEU LTD Plan.

Declaration:

☐ I declare the information I have entered is accurate and factual. I understand and agree to the terms under the income declaration and reimbursement section.

I authorize the use of my Social Insurance Number for the 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 _____ Month _____ Day of _____ Year.

Your name (please print): Signature:

_____ _____

Please attach copies of any correspondence or documentation relating to other income including WCB, SGI or CPP Notice of Entitlement or CPP Payment Explanation Statement, approval or denial letters, and notices of appeal.

Mail:
Attention: SGEU Disability Management Services
1011 Devonshire Drive North
Regina, SK. S4X 2X4

Fax:
1-306-775-5775
Email:
LTD@SGEU.ORG

SASKATCHEWAN BLUE CROSS®

DIRECT DEPOSIT REQUEST
SGEU LTD PLAN MEMBER

_____	N/A	51828
(Plan Member Name)	(Blue Cross ID Number)	(Contract Number)

I hereby authorize that my SGEU LTD Benefits be paid through electronic fund transfers (direct deposit) into this account.

Date: _____ Signature: _____

Please enclose this form, along with an unsigned VOID cheque and return to:

SGEU Head Office
1011 Devonshire Dr N
Regina SK S4X 2X4

PLEASE ATTACH A COPY OF A VALID PIECE OF ID WHICH SHOWS YOUR FULL DATE OF BIRTH

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

SGEU Long Term Disability Benefits Employee's Job Demands

This form is required for the submission of an SGEU LTD Plan Claim

- To be completed by your direct supervisor or delegate
- Include this completed form along with your Claim Application
- 3 pages

Part 1 – Member / Employee Information

MEMBER / EMPLOYEE IDENTIFICATION (Please Print)

Last Name:	**First Name:**	**Middle Initial:**

Employer:	**Job Title:**	**Department:**

Part 2 – Job Demands – To Be Completed by Employer

STRENGTH		**WEIGHT**		**FREQUENCY PERFORMED OVER 8 HOUR DAY**				
		Max	Usual	Not performed	Performed not daily	1-33% of workday	34-66% of workday	67-100% of workday
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								

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SGEU Long Term Disability Benefits Employee's Job Demands

		FREQUENCY				
		Not performed	Performed not daily	1-33% of workday	34-66% of workday	67-100% of workday
SENSORY / PERCEPTUAL						
Hearing	Conversation					
	Other Sounds					
Vision	Far					
	Near					
	Colour					
	Depth					
Reading						
Writing						
Speech						
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						
OTHER CONDITIONS OF WORK						
Travel						
Working on call						
Working overtime						
Shift work						
Equipment/machinery/vehicle operation						
Deadlines to be met						
Decision making						
Depend on others for information						
Boredom						
Work with public						
Speak with public						
Speak to groups						
Work independently						
Work in isolation						
Physical mobility in work						

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SGEU Long Term Disability Benefits Employee's Job Demands

Other Demands (include frequency and description):

☐ **I certify the information given on this claim form is true, correct, and completed to the best of my knowledge.**

Supervisor's Name: _____ Job Title: _____

Supervisor's Signature: _____ Date:_____

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
FAX: (306)775-5775

Claim for SGEU Long Term Disability Benefits Physician's Initial Report

Instructions:

The Patient is responsible for any fees related to the completion of this form

Return this form to your patient for submission to the SGEU LTD Plan

Part 1 – Identification and Authorization: To be completed by Member / Patient

Member's Name (Last, First, Middle Initial)	**Home Phone:**	**Cell Phone:**

Address (Box number, Street, City, Province, Postal Code)

Date of Birth (mm/dd/yy)	**Height**	**Weight**

Last Date Worked (mm/dd/yy)	**Date Returned to Work or Expected Return to Work Date (mm/dd/yy)**

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to the SGEU LTD Plan and/or the Plan's third-party medical adjudicator, and/or any of its authorized agents or representatives for the purposes of determining eligibility for coverage, claims adjudication and payment. This information includes, but is not limited to, copies of consultation reports, my medical history, clinical notes, test results and hospital records.

I understand that my personal health information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

Member's Signature	**Date (mm/dd/yy)**

Part 2 – To be Completed by the Physician (or Nurse Practitioner Where Applicable)

Primary Diagnosis

Secondary and/or Complications

Date of first visit to you pertaining to this condition (mm/dd/yy)	**First date of work absence (if known) due to this condition** (mm/dd/yy)

Occupational (Workplace) Illness/Injury Yes ☐ No ☐ If yes, date of event: (mm/dd/yy)	**Auto Accident** Yes ☐ No ☐ If yes, date of event: (mm/dd/yy)

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FAX: (306)775-5775

Claim for SGEU Long Term Disability Benefits
Physician's Initial Report

Part 3 – Investigations

Please attach copies of all relevant:

- Test results / investigations (if test results are not attached, we will interpret this as tests were not performed)
- Consultation reports
- Do not provide generic test results

Are any tests/investigations pending? Yes ☐ No ☐

	Date (mm/dd/yy)	Description
1.	_____	_____
2.	_____	_____

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (mm/dd/yy)
1.	_____	_____	_____
2.	_____	_____	_____

Clinical Findings and Observations

A) Describe patient's symptoms, severity, and frequency.

B) Provide a summary of objective examination findings and clinical observations.

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Regressed ☐

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

Are there other complicating factors that may impact the patient's expected recovery period and return-to-work?

Yes ☐ No ☐

☐ Addictions	☐ Social/Family Issues	☐ Financial/Legal Problems	☐ Pre-existing Medical Condition
☐ Physical Conditions	☐ Alcohol/Drug Abuse	☐ Medication Side Effects	☐ Work Environment
☐ Pain Perception	☐ Coping Skills	☐ Personality/Motivation	☐ Other

Please elaborate including a description of any supports in place, or planned, to assist with these barriers:

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Claim for SGEU Long Term Disability Benefits
Physician's Initial Report

Prognosis
Please provide the patient's prognosis for improvement and / or recovery:

Return-to-Work
What return-to-work goals have been discussed with the patient? Please elaborate:

Part 4 – Treatment

☐ **No active treatment is required.**

Current Treatment: (e.g. Special Programs and therapies)

	Treatment start date (mm/dd/yy)	Frequency	End date (if known) (mm/dd/yy)
☐ Medical/Surgical Specialist			
☐ Psychiatrist			
☐ Psychologist			
☐ Counsellor (social work / mental health worker)			
☐ Physical / Exercise Therapist			
☐ Chiropractor			
☐ Education / Other Treatment Problems			
☐ Other			

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (mm/dd/yy) _____

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (mm/dd/yy) _____ Treatment Provider: _____

List all prescribed medications (dosage/frequency/start date):

	Name of Medication	Dosage (mg)	Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
1.					
2.					
3.					
4.					
5.					

List previous medications trialed and general response:

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Claim for SGEU Long Term Disability Benefits
Physician's Initial Report

Do the medication(s) impair safety in the workplace for the patient or for others? Yes ☐ No ☐

Has the patient been fully compliant with the prescribed treatment plan? ☐ Yes ☐ No

If no, explain:

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If yes, please explain:

Part 5 - Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No **Is future hospitalization planned?** ☐ Yes ☐ No

	Date of admittance	Date of discharge	Institution name
1.			
2.			
3.			

If surgery was / will be performed, please provide date(s) and description of surgery(s):

	Date (mm/dd/yy)	Description
1.		
2.		
3.		
4.		
5.		

Part 6 - Return to Work – Restrictions / Limitations

Is the Patient currently working? ☐ Yes ☐ No **Participating in activities of daily living?** ☐ Yes ☐ No

Is the Patient fit to return to modified / alternate duties? ☐ Yes ☐ No
If yes, provide estimated date (mm/dd/yy): _____

If 'Yes' in questions above, does the Patient have:

☐ Physical Restrictions / Limitations (Fill in Part 7.1 Physical Restrictions / Limitations Section)

☐ Cognitive or Psychological Restrictions / Limitations (Fill in 7.2 Cognitive / Psychological Restrictions Section)

If 'No' in question above, please explain in detail the medical contraindications, concerns or functional limitations which preclude your patient from participating in any employment activities at this time.

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FAX: (306)775-5775

Claim for SGEU Long Term Disability Benefits
Physician's Initial Report

Part 7 - Restrictions / Limitations

7.1 PHYSICAL LIMITATIONS		Hours at one time					Total hours during 8 hr. day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Sitting	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ladder and Stair Climbing	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kneeling/Crawling Crouching	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Driving/Operate Vehicle	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

This patient can lift/carry a maximum of: _____kgs. _____lbs.		0kgs 0lbs	5kgs 10lbs	9kgs 20lbs	14kgs 30lbs	18kgs 40lbs	23kgs 50lbs	27kgs 60lbs	32kgs 80lbs	36kgs 80lbs	41+kgs 90+lbs
☐ No Restriction	☐ Repetitively – how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally – how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reaching / Repetitive Arm Movements ☐No Restriction	Left Arm limited to: ☐ below waist ☐ waist level ☐ chest level Right Arm limited to: ☐ below waist ☐ waist level ☐ chest level
Manual Dexterity (Grip / Twist / Keyboarding) ☐No Restriction	☐ Left hand / arm ☐ Right hand / arm ☐ Fine motor skills (pick up small items; writing; using computer mouse) ☐ Gripping / twisting / pulling ☐ Keyboarding: Limit to _____hrs / day

In your opinion, does the patient have any cognitive or psychological difficulties that could negatively impact their ability to work and/or their performance within the workplace? If yes, fill below.

7.2 COGNITIVE / PSYCHOLOGICAL LIMITATIONS	Level of impairment			
	No Impact	Mild	Moderate	Severe
Memory processing or recalling information	☐	☐	☐	☐
Concentration/focus	☐	☐	☐	☐
Comprehending new information	☐	☐	☐	☐
Problem-solving	☐	☐	☐	☐
Complex numerical calculations	☐	☐	☐	☐
Insight/judgement	☐	☐	☐	☐
Analyzing information/data	☐	☐	☐	☐
Completing tasks with frequent interruptions	☐	☐	☐	☐
Tolerating unusual and shifting deadline pressures	☐	☐	☐	☐
Socialization/handling conflict	☐	☐	☐	☐
Experiences excessive mental fatigue every day	☐	☐	☐	☐
Experiences excessive physical fatigue every day	☐	☐	☐	☐

Observations or comments supporting the above:

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
FAX: (306)775-5775

Claim for SGEU Long Term Disability Benefits
Physician's Initial Report

Part 8 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)		
The information in this statement will be kept in a disability benefits file with the SGEU LTD Plan and third-party medical adjudicator and may be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.		
Attending Physician (please print)	**Practitioner Number**	**Physician's Stamp**
Address (Street, City, Province, Postal Code)		
Telephone # (+Area Code)	Fax # (+Area Code)	
Email Address		
Signature	**Date Signed (mm/dd/yy)**	

Instructions:

The patient is responsible for any fees related to the completion of this form.

Return this form to your patient for submission to the SGEU LTD Plan.

Fax: (306) 775-5775

FORM # 1
REQUEST OR RELEASE OF INFORMATION

GROUP LIFE, EXTENDED HEALTH & DENTAL PLANS

***Third Party Requests*:** I authorize the SGEU LTD Plan, or any of its agents or representatives, to release or share any relevant personal, health and/or claim information including, but not limited to the status, benefits, medical, or vocational reports and/or any other information deemed necessary to my group life insurance plan, extended health or dental plan insurer(s).

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, or any of its agents or representatives, to collect, use or disclose any relevant personal or health information including, but not limited to the status, coverage, benefit amounts or waivers, medical or vocational/RTW (return to-work) reports and/or any other information deemed necessary for the administration of my LTD claim.

Information may be discussed with any agent or representative of the SGEU LTD Plan and third party (as listed above) via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 2
REQUEST OR RELEASE OF INFORMATION

REPRESENTATIVE(S)

***Representative Requests*:** I authorize the SGEU LTD Plan and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to release or share any personal or health and/or claim information including, but not limited to the status, benefits, financial details, medical, or vocational/RTW reports, or any other information that may be requested by my representative(s) as per Form # 2.

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to collect, use or disclose any personal or health information from my representative(s), but not limited to medical documents or vocational/RTW (return to-work) reports and/or any other information deemed necessary during the administration of my LTD claim.

Information may be discussed with my representative(s) and/or the SGEU LTD Plan or the Plan's medical adjudicator via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

NOTE: A representative may be your spouse, partner, family member, friend, SGEU Union Representative, or another contact person of your choice.

Name of Representative(s)	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 3
REQUEST OR RELEASE OF INFORMATION

PHYSICIAN(S), HEALTH CARE PROVIDERS, HOSPITALS

***Third Party Requests*:** I authorize the SGEU LTD Plan and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to release or share any relevant personal, health, or medical and/or claim information including, but not limited to the status, benefit period, medical documents, or vocational/RTW (return to-work) reports and/or any other information deemed necessary for my physician(s) or other health care provider(s).

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to collect, use or disclose any relevant personal, health or medical information from my physician(s), health care provider(s), hospitals, or treatment facilities including, but not limited to assessments, diagnostics, consultations, treatment, or vocational/RTW (return to-work) reports and/or any other information deemed necessary for the administration of my LTD claim.

Information may be discussed with any agent or representative of the third party or the SGEU LTD Plan via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 4
RELEASE OF INFORMATION – PENSION PLAN

PLANNERA PENSION & BENEFITS PLAN (PPBP)
PUBLIC EMPLOYEES PENSION PLAN (PEPP)
SASK HEALTHCARE EMPLOYEES' PENSION PLAN (SHEPP)
MUNICIPAL EMPLOYEES' PENSION PLAN (MEPP)

NOTE: This form authorizes communication with only the member's pension plan to which they belong or have made contributions.

***Third Party Requests*:** I authorize the SGEU LTD Plan and/or the Plan's medical adjudicator, and/or any of their agents or representatives, to release or share any relevant personal (excludes health or medical information), employment and/or claim information including, but not limited to the status, approval/termination of TD benefits, benefit amounts or financial details, pension deductions or adjustments, and/or any other information that may be requested by my pension plan.

SGEU LTD Requests: I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of their agents or representatives, to collect, use or disclose any relevant personal (excludes health or medical information), employment, financial or pension-related details including, but not limited to my eligibility for pension, access/transfers/withdrawals of any employer pension funds, an estimated 15-year single life annuity statement (if eligible for bridge funding), resignation/termination/retirement dates and/or any other information deemed necessary during the administration of my LTD claim.

Information may be discussed with any agent or representative of the third party, the SGEU LTD Plan and/or the LTD Plan's medical adjudicator via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 5
RELEASE OF INFORMATION

SASK WORKERS' COMPENSATION BOARD (WCB)

***Third Party Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, or any of their agents or representatives, to release or share any relevant personal, health and/or LTD claim information including, but not limited to the status, adjudicative decisions such as approval/termination of LTD benefits, benefit amounts or financial details, medical documents or vocational/RTW reports and/or any other information deemed necessary by the Sask WCB.

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of their agents or representatives, to collect, use or disclose any relevant personal, health, and/or WCB claim information including, but not limited to the approval or termination decisions, benefit or financial details, medical reports or vocational/RTW documents and/or any other information deemed necessary during the administration of my LTD claim.

Information may be discussed with any agent or representative of the third party, the SGEU LTD Plan and/or the Plan's medical adjudicator via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 7
RELEASE OF INFORMATION

EMPLOYER and/or SGEU LABOUR RELATIONS OFFICER(S)

Third Party Requests*:** I authorize the SGEU LTD Plan, and/or any of their agents or representatives, to release or share any relevant personal, health, work or labour-related information, or any pertinent vocational/RTW (return-to-work) details including, but not limited to the LTD benefit period, prognosis for recovery, medically prescribed limitations/restrictions, accommodation requirements, workplace and/or performance issues, harassment and/or conflict, or any other information deemed necessary for vocational/RTW planning. ***NO CONFIDENTIAL MEDICAL DOCUMENTS AND/OR INFORMATION PERTAINING TO MY DIAGNOSES, CONDITION(S), OR TREATMENT REGIME WILL BE RELEASED OR DISCLOSED WITH ANY EMPLOYER AGENTS OR REPRESENTATIVES OR SGEU LABOUR RELATIONS OFFICER(S).

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, and/or any of their agents or representatives, to collect, use or disclose any relevant personal or claim-related information including, but not limited to the approval/termination of benefits, functional health issues impacting ability to work, or medically prescribed recommendations pertinent to the vocational/RTW process, and/or any work or labour-related information including, but not limited to job attendance or performance issues, or reports of workplace conflict/harassment and/or any other information deemed necessary during the administration of my LTD claim.

Information may be discussed with any agent or representative of the third parties (as cited above) and/or the SGEU LTD Plan via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM # 8
RELEASE OF INFORMATION

SASK GOVERNMENT INSURANCE (SGI)

***Third Party Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, or any of their agents or representatives, to release or share any relevant personal, health and/or LTD claim information including, but not limited to the status, adjudicative decisions such as approval /termination of LTD benefits, benefit or financial details, medical documents or vocational/RTW (return to-work) reports, and/or any other information deemed necessary by SGI.

***SGEU LTD Requests*:** I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of their agents or representatives, to collect, use or disclose any relevant personal, health and/or SGI claim information including, but not limited to the approval/termination decisions, benefit amounts or financial details, medical documents or vocational/RTW reports, and/or any other information deemed necessary during the administration of my LTD claim.

Information may be discussed with any agent or representative of the third party, the SGEU LTD Plan and/or the Plan's medical adjudicator via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____

FORM #9

ELECTRONIC DOCUMENTATION

I hereby authorize and direct the SGEU Long Term Disability Plan and/or the plan's medical adjudicator to contact me electronically regarding any aspect of my application and/or claim file (including but not limited to, requesting documents, requesting dues, updating contact information, etc)

By providing an email address, I consent to having this information added to my application and/or claim file.

Email: _____

_____
Member's Name

_____
Signature

_____
Date

This consent 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.