



Help us to process your claim quickly and accurately. Ensure that the following forms are completed and that the originals of these forms are submitted:

- Long Term Disability Claim Form
- Initial Attending Physician's Statement
- Claimant Questionnaire
- Employer Questionnaire
- Job Analysis Form

Your claim for this benefit must be submitted to BC Life by your policy claiming deadline. If you have any questions about your claim or about these forms, please contact our BC Life Claims Department at 604 419-8040.

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1



Employer's Statement

Name of group policyholder _____ Policy number _____

Name of employee _____ Social insurance number _____

Date employed

Mo	Day	Yr

 Job title (attach details of job description) _____

Date last worked

Mo	Day	Yr

 Salary paid up to and including

Mo	Day	Yr

 Regular number of hours worked per week _____

Monthly basic earnings on last day worked \$ _____ Date of last salary increase

Mo	Day	Yr

Date returned to work (if applicable)

Mo	Day	Yr

 Part time Full time Number of hours per day/week (specify) _____

If returned to work, what job did this employee return to? _____

Are there any jobs with your company that this employee is qualified to do and might do either now or in the future? Yes No

If yes, please provide the job title and a brief summary of the duties _____

Has the employment been terminated? Yes No If yes, provide date terminated

Mo	Day	Yr

 and reason _____

Why did your employee stop working? _____

Is this condition work related? Yes No If yes, provide copies of WCB accident report and available correspondence.

Effective date of employee's LTD insurance

Mo	Day	Yr

 Date insurance terminated (if applicable)

Mo	Day	Yr

LTD monthly benefits: \$ _____

Does the employee pay 100% of the LTD premium? Yes No

Is the employee entitled to any of the following: sick pay Yes No If yes, indicate date income expires

Mo	Day	Yr

Short Term Disability Yes No If yes, indicate date income expires

Mo	Day	Yr

WCB Yes No If yes, indicate date income expires

Mo	Day	Yr

If entitled to income other than the above, please explain: _____

Please provide any other information that will help BC Life assess this claim _____

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Completed by (please print) _____ Date

Mo	Day	Yr

Phone number _____ Fax number _____

Signature of authorized official _____ Title _____

Employee's Statement (to be completed by employee)

Name _____ Date of birth

Mo	Day	Yr

Married: Yes No

Name and birth dates for your dependent children	Name	Date of birth						
_____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
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Mo	Day	Yr						

Address _____ Box no. (if applicable) _____

City _____ Province _____ Postal Code _____ Phone number _____

Job title (occupation) _____ Date last worked

Mo	Day	Yr

Description of illness or injury that prevents you from working _____

Have you had this or any related condition before? Yes No If yes, explain _____

List all physicians, surgeons and practitioners you have seen during the past three years.

Name	Address	Dates of attendance	Disease or condition						
_____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr	_____
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Mo	Day	Yr							

Have you been hospitalized for this condition? Yes No If yes, provide hospital information below:

Name of hospital	Date admitted	Date discharged												
_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr												
Mo	Day	Yr												

Provide details on the treatment you have been or are receiving _____

Explain the changes/improvement you have noted since you started treatment _____

Indicate which benefits you have **applied for, are receiving or expect to receive** from any of the following sources:

Source	Amount	Weekly or monthly	Date payment began or date applied for						
<input type="checkbox"/> Canada Pension Plan Disability Benefit <small>(attach copy of "Notice of Entitlement or Decline letter")</small>	\$ _____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr							
<input type="checkbox"/> Workers' Compensation	\$ _____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr							
<input type="checkbox"/> Employment Insurance	\$ _____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr							
<input type="checkbox"/> Automobile Insurance	\$ _____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr							
<input type="checkbox"/> Other (pension plans, STD etc..) Specify	\$ _____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr><tr><td>Mo</td><td>Day</td><td>Yr</td></tr></table>				Mo	Day	Yr
Mo	Day	Yr							

Have you been able to return to work since your injury or the start of your illness? Yes No If yes, give dates

Mo	Day	Yr

Are you now working? Yes No If yes, date of return

Mo	Day	Yr

 Hours worked per day or per week _____

Name of employer _____ Job title _____

If not returned to work, when do you anticipate returning to work? _____

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I authorize any Employer, Insurance Company, Workers' Compensation Board, Service Organization, Physician, Practitioner or other person; any hospital or other institution to release to or obtain from British Columbia Life & Casualty Company or my employer, any medical or benefit payment information that may be required to establish the validity of this claim, and further authorize said company, person, or organization, to disclose any personal or claim information required for medical case study or review. A photocopy of this authorization shall be as valid as the original. If I receive a Disability Benefit payment greater than that which should have been paid, I understand that British Columbia Life & Casualty Company has the right to recover such overpayment from me, including the right to reduce future Disability Benefits, if any. I certify that the above answers are true and correct to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of employee _____ Date

Mo	Day	Yr



Initial Attending Physician's Statement

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Please assist your patient by providing all details relevant to his/her condition. Cross out those questions that are not applicable.

1. Name of patient: _____ Date of birth:

Mo	Day	Yr

2. Patient's: Height _____ Weight _____ Male Female

3. Diagnosis: _____

4. Additional conditions or complications: _____

5. Does your patient require treatment for substance abuse? Yes No If yes, is this treatment under way, what type of treatment and when did it start?

6. DSM IV (if applicable): _____ GAF score: _____

7. Objective findings (please include copies of test results: current X-rays, diagnostic tests, E.K.G.'s, blood pressure readings, etc.):

8. Subjective complaints (including severity and frequency): _____

9. Date symptoms began:

Mo	Day	Yr

 Date your patient stopped work due to these symptoms:

Mo	Day	Yr

10. Has your patient ever had the same or similar condition? Yes No If yes, when, and provide details: _____

11. Is this condition caused in any way by the patient's employment? Yes No If yes, have you submitted a WCB claim form? Yes No

12. Date of first visit:

Mo	Day	Yr

 Date of most recent visit:

Mo	Day	Yr

13. Frequency of visits: Weekly Monthly Other (specify): _____

14. Medications: provide type, start date, dosage and frequency, response and adjustment date if applicable _____

15. Please provide details of other treatment (surgery, physiotherapy, psychotherapy, etc.) including dates, recommended frequency, etc. _____

16. Is your patient following the recommended treatment? Yes No If no, please comment: _____

17. Names, addresses and specialty of other physicians or treatment providers referred to: **(please include copies of any consultation and follow up reports)**

Name	Address	Specialty
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. Has your patient been hospitalized? Yes No If yes, provide dates Date admitted

Mo	Day	Yr

 Date discharged

Mo	Day	Yr

Name and address of hospital: _____

19. What are your patient's mental and physical limitations and how do they affect the activities of daily living? _____

20. Has your patient: recovered improved not improved retrogressed

21. If appropriate treatment is followed, do you expect your patient to return to pre-illness/accident functioning? Yes No

If yes, when? _____

If no, please explain _____

22. If there are other factors, please explain _____

23. Do you believe your patient is competent to endorse cheques and direct the use of the proceeds? Yes No

24. Please provide any additional information you believe we should be aware of concerning your patient's condition:

These statements are true and correct to the best of my knowledge and belief.

Name and specialty (please print) _____

Address (please print) _____ Phone Number _____

Signature _____ MD Date _____



This form must be completed by the employee's supervisor

Name of group policyholder _____ Policy number _____

Name of employee _____ Social insurance number _____

Job title _____ Worksite location _____

Number of hours worked per day _____

Indicate **number of times per day** the listed activity is performed.

LIFTING (includes pushing and pulling effort while stationary)

- 1 - 5 lbs.
- 6 - 10 lbs.
- 11 - 25 lbs.
- 26 - 50 lbs.
- 51 - 100 lbs.
- 100 lbs. +

CARRYING (includes pushing and pulling effort while walking)

- 1 - 5 lbs.
- 6 - 10 lbs.
- 11 - 25 lbs.
- 26 - 50 lbs.
- 51 - 100 lbs.
- 100 lbs. +

Indicate **number of hours per day** each activity is performed.

- | | | |
|---|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Kneeling | <input type="checkbox"/> R Finger dexterity |
| <input type="checkbox"/> Total time on feet | <input type="checkbox"/> Inside | <input type="checkbox"/> L Finger dexterity |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Outside | <input type="checkbox"/> R Reaching below shoulders |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Working with others | <input type="checkbox"/> L Reaching below shoulders |
| <input type="checkbox"/> Legs only -(i.e. stairs) | <input type="checkbox"/> Working around others | <input type="checkbox"/> R Reaching above shoulders |
| <input type="checkbox"/> Legs & arms - (i.e. ladders) | <input type="checkbox"/> Working alone | <input type="checkbox"/> L Reaching above shoulders |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> Other (explain) _____ | |

Occupational requirements: **answer yes or no.**

- Far - vision Yes No Near - vision Yes No Depth - perception Yes No
- Hearing Yes No Talking Yes No Other (explain) _____

Does occupation involve exposure to these conditions: **answer yes or no.**

- | | |
|--|--|
| Hazardous machinery <input type="checkbox"/> Yes <input type="checkbox"/> No | Cluttered floors <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Electrical hazards <input type="checkbox"/> Yes <input type="checkbox"/> No | Exposure to burns <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Poor lighting <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor ventilation <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wet quarters <input type="checkbox"/> Yes <input type="checkbox"/> No | Vibration <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Noise <input type="checkbox"/> Yes <input type="checkbox"/> No | Dust or fumes <input type="checkbox"/> Yes <input type="checkbox"/> No |

Completed by (please print) _____ Title _____

Signature _____ Date

Mo	Day	Yr

PLEASE ATTACH DETAILS OF JOB DUTIES



Disability Claim Employer Questionnaire

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Name of employee _____ Policy number _____ Social insurance number _____

Job title _____ Number of years performing this job _____

This questionnaire is designed to help us assess your employee's claim for disability benefits. It also gives you, the employer, an opportunity to contribute to this process by providing any insight that you consider relevant. If insufficient space, please use separate sheet.

1. To your knowledge, how many days has your employee missed work in the past two years due to the condition which resulted in this claim?

2. Did your employee's work performance change in any way within the six months immediately preceding this absence from work? Yes No

If yes, please explain how it changed. If this change was discussed with your employee, what was the end result?

3. Was your employee doing all of the duties of his or her job immediately preceding this absence from work? Yes No If no, please describe how the job had been modified.

4. Has your employee's job been filled? Yes No If yes, Temporary Permanent

5. Has your employee contacted you about a return to work? Yes No If yes, please recap your discussion. _____

6. Would you accommodate your employee in a gradual return to work and/or a modified return to work program? Yes No

Please explain: _____

7. Has your employee had more than one job with your company? Yes No If yes, list all job titles and time spent at each job.

8. If your employee's skills can be used in another job within your company, please explain. _____

9. To assist us in the management of your employee's claim, please comment on other factors such as your employee's general work record, absentee record, motivation, attitude towards the job, etc.

Completed by (please print) _____ Title _____

Signature _____ Date

Mo	Day	Yr
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Name of claimant _____ Social insurance number _____

Occupational Information

Your job title _____ Number of years performing this job _____

Describe the essential duties of your job. _____

Is there any specialized equipment you are required to use on a daily basis? Yes No If yes, please describe: _____

Please indicate the approximate number of hours you are involved in the following activities during your normal work day:

Walking _____ Standing _____ Sitting _____ Bending _____

Only complete this section if your job involves *lifting, carrying and reaching*. Please check in the applicable spaces below, those physical activities required in your job.

Physical activities required	Total hours performed daily				
	Less than 1	1-2	3-4	5-6	7-8
LIFTING	<input type="checkbox"/> under 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> 11 - 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> 21 - 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> over 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARRYING	<input type="checkbox"/> under 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> 11 - 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> 21 - 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> over 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACHING	<input type="checkbox"/> Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Reaching at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Reaching below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you expect to be able to return to your job in the near future? Yes No If yes, on a part-time or full-time basis? _____

Do you believe your duties can or will need to be modified in order to allow you to return? Yes No Please explain: _____

Have you discussed a return to work with your employer, either to your present job, or to some other position with your company? Yes No

If yes, provide details of discussion. _____

Medical Information

Please describe any limitations and restrictions you have as a result of your medical condition(s). _____

Describe in detail the way in which your symptoms prevent you from performing any or all of the essential duties of your job. _____

Education and Employment Background

Highest grade achieved (please circle) 1 2 3 4 5 6 7 8 9 10 11 12 13

Technical or trade school attended _____ Diploma obtained _____

Apprenticeships _____

College or University:

(a) Name of college or university _____

(b) Years completed _____ (c) Degree obtained _____ (d) Major _____

Other (vocational courses, programs, training, certificates, etc. and year completed or obtained) _____

Language(s) spoken fluently _____

Please complete the following, providing details on the jobs you have held (last job first). If insufficient space, please attach a separate sheet.

Employer	Job title	Dates of employment	Essential job duties performed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Skills and Interests

What job skills have you acquired in your current and previous jobs? _____

Please describe any community projects or volunteer work that you are or have been involved with. _____

What are your hobbies or interests? _____

Are there any jobs that you are interested in, such as ones based upon your hobbies/interests, previous work experience, and/or education?

Do you currently have: a) a valid driver's license? Yes No What class? _____

c) any driving restrictions as a result of your condition? Yes No Explain _____

b) a car Yes No

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Signature of claimant _____ Date

Mo	Day	Yr
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