Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Employee Statement for Short Term Disability (STD) Benefit Coverage

Send to:
Email: luene@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

1) Employee Information

Last Name:	First Name:	Date of Birth: (mm/dd/yy)	Employee Number:
Home Address:	City:	Province:	Postal Code:
Home Phone:	Email Address:		
Job Position/Title:	Date of Hire: (mm/dd/yy)	Social Insurance Number:	

2) Employer Information

Group Number:	Employer Name:	Employer Phone Number:	
Address:	City:	Province:	Postal Code:
Managers Name:	Direct Line (if applicable):		

3) Claim Information

Nature of Condition:

Is this Disability due to an accident? ◯ Yes ◯ No If Yes, provide date accident occurred: (mm/dd/yy)

Is the accident work related? ◯ Yes ◯ No

Provide details of accident:

From what date has your disability continuously prevented you from performing regular work? (mm/dd/yy)

Have you performed **other** work since that date? ◯ Yes ◯ No

If Yes, describe:

Are you able to do any other work? ◯ Yes ◯ No If Yes, describe:

Please provide the name (s) and phone number (s) of your attending physician(s):

4) Financial Information

Have you applied for, or are you receiving the following:

Copies of initial Statements must be provided if you are receiving any of the below listed benefits.

	Applied	Receiving	Amount
Canada Pension Plan /Quebec Pension Plan Benefits	◯ Yes ◯ No	◯ Yes ◯ No	
Workers Compensation Board Benefits (or similar plan)	◯ Yes ◯ No	◯ Yes ◯ No	
Employment Insurance Benefits	◯ Yes ◯ No	◯ Yes ◯ No	
Automobile Insurance Benefits	◯ Yes ◯ No	◯ Yes ◯ No	
Any other Disability Benefits	◯ Yes ◯ No	◯ Yes ◯ No	
Employer Sponsored Retirement/Pension Plan Income	◯ Yes ◯ No	◯ Yes ◯ No	
Self-Employment or any other Employment Income		◯ Yes ◯ No	
Any other Income	◯ Yes ◯ No	◯ Yes ◯ No	

If your claim is approved, it is your responsibility to notify Health Risk Services of *any* work performed, whether or not you have received a wage or remuneration and/or *any* employment income paid to you or any other person/party as a result as work performed by you. Failure to do so will result in immediate termination of claim.

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INSTRUCTIONS

1. Please **READ and INITIAL** in the boxes provided in both the **PRIVACY** and **AUTHORIZATION/DECLARATION** sections of this page.
2. **Your SIGNATURE is required at the bottom of the form.**
3. Should you have any questions regarding either of these statements, please contact Health Risk Services directly prior to submitting your enrolment.

YOUR PRIVACY – Respecting and Protecting your Personal Information

At Health Risk Services we recognize and respect the importance of privacy. When you apply for coverage, we will establish a ***confidential file*** that contains your personal information. The information that we collect will be used for the purposes of determining your eligibility for coverage for the plan you are applying for and for the administration of this plan. This would include investigating and assessing claims, and creating and maintaining records concerning our relationship. Your file will be kept in the office of Health Risk Services. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Health Risk Services. We limit access to personal information in your file to Health Risk employees, to persons you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. To review the entire Health Risk Services Privacy Guidelines, visit the Health Risk website: **www.healthrisk.ca** – Privacy Guidelines

Initials ☐
*Required

AUTHORIZATION AND DECLARATIONS

I AUTHORIZE any physician, health practitioner, clinic or hospital or other medical organizations or any provincial motor vehicle board, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Health Risk Services Inc. having relevant information available as to my diagnosis, treatment and prognosis with regard to any physical or mental condition and/or treatment or tests completed on me, to provide to Health Risk Services Inc. and its duly authorized agents or representatives any and all such information to evaluate my application for benefits under the Short Term Disability Plan.

I hereby authorize Health Risk Services Inc., or such designated agent or successor as may be appointed and their respective authorized agents, including their legal represen- tatives and investigators, to obtain, collect, receive, retain, examine, copy and disclose any personal information or personal health information, including consultation reports from or to any physician (including my treating physician) and/or any other medical practitioner, hospital, clinic, legal counsel, investigative agency, the Long Term Income Protection Plan Administrator and insurance company.

The purpose for which this information is collected and for which it may be disclosed is i) to adjudicate and manage my claim, ii) facilitate rehabilitation and return to work, iii) in the context of litigation or legal claims or the assessment thereof, iv) management of the employment relationship, and v) for the policy holder's statistical purposes.

I ACKNOWLEDGE that Health Risk Services Inc. reserves the right to undertake an independent medical examination or consultation with my attending physician(s) for the purpose of determining my eligibility for payment of Short Term Disability benefits and provide a copy of any independent medical examination report to my treating physician(s).

I AGREE that any information provided to Health Risk Services Inc. may be used by them for the assessment of my claim, and for any other purpose relating to the administra- tion of my Short Term Disability benefits, including, but not limited to, use in assisting in my reintegration into the workplace. Only information related to work restrictions or fitness to work will be released to my Employer.

Initials ☐
*Required

SIGNATURE

I certify that all information I have given is true, correct and complete to the best of my knowledge.

Plan Member Signature:	**Date Signed: (mm/dd/yy)**