SGEU
WORKING TOGETHER FOR SASKATCHEWAN

Saskatchewan Government and General Employees' Union

LONG TERM DISABILITY

www.sgeu.org

1011 Devonshire Drive North,
Regina, SK S4X 2X4
(p) 522.8571
1.800.667.5221
(f) 775.5775
(e) ltd@sgeu.org

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 **calendar** days. As per Article 11.1 of the SGEU LTD Plan Text you are required to apply for Long Term Disability benefits within one year from date of disability.

5. If you have any questions regarding the SGEU LTD Plan, contact a LTD 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

Check List for the Completion of
The SGEU Long Term Disability Claim Forms

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.** This date should reflect **the day after** your last physical day at work.
  - ❑ 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 or a bank authorization form.
- ❑ **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.**
- ❑ Release of Information # **1** - Complete this form to provide information on group life, extended health and dental insurance.
- ❑ Release of Information # **2** - Complete this form for release of your LTD Claim information to a person that can speak on your behalf.
- ❑ Release of Information # **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 # **4.1, 4.2 or 4.3** - Complete the applicable form to provide information on pension contributions and/or status.
- ❑ Release of Information # **5** - Complete this form for release of your W.C.B. Claim information.
- ❑ Release of Information # **7** – Complete this form for release of your employment information. No medical information will be provided to your employer.
- ❑ Release of Information # **8** – Complete this form for release of your SGI Claim information.
- ❑ Release of Information # **9** – Complete this form for SGEU LTD Plan and the plan's medical adjudicator to enable contact electronically (via email).

Check List for the Completion of

The SGEU Long Term Disability Claim Forms

Notes:

- **As per Article 11.1 of the SGEU LTD Plan you must submit your LTD application within one year of date of disability. In addition to the below requirements you should submit your Long Term Disability application within the elimination period.**

- 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.

08/2018

Saskatchewan Government and General Employees' Union

WORKING TOGETHER FOR SASKATCHEWAN

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1011 Devonshire Drive North,
Regina, SK S4X 2X4
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(f) 775.5775
(e) ltd@sgeu.org

LONG TERM DISABILITY

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 Kelsey Cattell, 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. Shane can be contacted, toll-free, at 800-667-5221, ext. 204, direct line: 306-775-7204, e-mail: "sosberg@sgeu.org".

Angie Rabak, 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, Angie can be contacted, toll-free, at 800-667-5221, ext. 213, direct line: 306-775-7213, e-mail: "arabak@sgeu.org".

Myrna Wilgosh, 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. Myrna can be contacted, toll-free, at 800-667-5221, ext. 873, direct line: 306-775-7873, e-mail: "mwilgosh@sgeu.org".

Rhonda Ross, 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. Rhonda can be contacted, toll-free, at 800-667-5221, ext. 215, direct line: 306-775-7215, e-mail: "rross@sgeu.org".

Amber Roussin, Advocate, is the contact person who assist 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. Amber can be contacted, toll-free, at 800-667-5221, ext 223, direct line: 306-775-7223, e-mail: "aroussin@sgeu.org".

Kelly Weldon, Tara Booker and Kelsey Cattell 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, Kelly can be contacted, toll-free, at 800-667-5221, ext. 231, direct line: 306-775-7231, e-mail: "kweldon@sgeu.org". Tara can be contacted, toll-free, at 800-667-5221, ext. 216, direct line: 306-775-7216, e-mail: "tbooker@sgeu.org". Kelsey can be contacted, toll-free, at 800-667-9791, ext. 393, direct line: 306-653-9393, e-mail: "kcattell@sgeu.org".

Denise Cox, 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. Denise can be contacted, toll-free, at 800-667-5221, ext. 209, direct line: 306-775-7209, e-mail: "ltd@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.

SGEU LTD Plan
1011 Devonshire Drive North
Regina SK S4X 2X4
Local: 306-522-8571
Toll Free: 800-667-5221

Claim for SGEU Long Term Disability Benefits

Part 1 – MEMBER'S STATEMENT

MEMBER IDENTIFICATION (Please Print)

Last Name: First Name: Middle Initial:

Female ☐ Male ☐ Other ☐

Address: City/Town: Province: Postal Code:

Social Insurance Number:	Date of Birth: **(ATTACH ID WITH DOB)**	Telephone No: Cell: Home:	Home Email Address:

Employer: Department:

Job Title: Shiftworker: ☐ No ☐ Yes

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? _____ (mm/dd/yy)

From what most recent date has your condition prevented you from working? _____ (mm/dd/yy)

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

When do you expect to be able to return to:
a) your own occupation? _____ (mm/dd/yy) b) any occupation? _____ (mm/dd/yy)

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

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

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		

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

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

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: _____ Date of Appeal:_____

5. Are you receiving Workers Compensation Board (**WCB**) or Saskatchewan Government Insurance (**SGI)** Income?
☐ No ☐Yes* (WCB) ☐Yes* (SGI)

If yes: Monthly Amount: _____ Dates of Payments: From _____ (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: _____ Date of Appeal:_____

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)

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 Member:

**Please attach copies of any correspondence or documentation relating to other income including notice of entitlement (notice of claim), denial letters, and notices of appeal.*

PHYSICIAN'S INITIAL REPORT FORM

Instructions:

Part 2 - To be completed by Member

Part 3 to 8 – To be completed/authorized by a Medical Doctor

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

Name and Address of Insurer: SGEU Long Term Disability Plan 1011 Devonshire Dr N Regina SK S4X 2X4	**Name of the Plan's Medical Adjudicator:** Saskatchewan Blue Cross
Member's Last Name First Initial	**Member's Mailing Address:**
Member's DOB (mm/dd/yy)	**Member's S.I.N.**
In respect to this form, I hereby authorize the release of any information to the Insurer and the Plan's Medical Adjudicator. **Member's Signature** **Date (mm/dd/yy)**	

Part 3 – History and Findings: *Part 3 to 8 to be completed/authorized by a **Medical Doctor.***

To provide further information on any physical or psychological Illness/Injury, complete the applicable portions of this form and attach any applicable documents (such as x-ray, scans, consult reports, etc.).

3.1 Mechanism of injury or onset of illness	
3.2 To the best of my knowledge, the illness/injury started or happened on (mm/dd/yy).	**3.3 To the best of my knowledge, the Patient has been unable to work as a result of the disability from (mm/dd/yy).**
3.4 Date of first examination for the present condition (mm/dd/yy).	3.5 Dates of hospitalization (mm/dd/yy) From To Name of hospital

Part 4 – Diagnosis

4.1 Diagnosis of Physical Illness/Injury:
4.2 Physical Clinical Findings:
4.3 Diagnosis of Psychological Illness/Injury:

4.4 Psychological Clinical Findings:

4.5 Diagnostic tests ordered and findings (Attach copies of all results):

4.6 Is the condition as a result of a **workplace** issue: ☐ Yes ☐ No

If yes, describe the workplace incident and any other contributing factors (alleged harassment/conflict, workload or performance issues).

Part 5 – Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicated the patient recovery period

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

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

Part 6 – Treatment Plan

☐ No active treatment is required.

6.1 Current Treatment: (specify in each case):

6.2 List all Medications (dosage/frequency/start date):

List previous medications trialed and general response:

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

6.3 Referred for assessment / treatment to (specify name and appointment dates):

☐ Medical/Surgical Specialist _____

☐ Psychiatrist _____

☐ Psychologist _____

☐ Counsellor (social worker/mental health worker) _____

☐ Physical Therapist _____

☐ Chiropractor _____

☐ Other Referral _____ _____

☐ Education/Other Treatment _____

6.4 Has the Patient been fully compliant with the prescribed treatment plan? ☐ Yes ☐ No (If no, explain)

Part 7 – Return to Work - Restrictions / Limitations

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

7.2 Is the Patient fit to return to modified / alternate duties? ☐ Yes ☐ No (If yes, on _____ mm/dd/yy)

If 'Yes' in questions 7.2 above, does the Patient have:

☐ Physical Restrictions / Limitations (Fill in the Physical Restrictions / Limitations Section below)

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

If 'No' in question 7.2 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.

Physical Restrictions / Limitations

		Hours at one time					Total hours during 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Reaching / Repetitive Movements ☐No Restriction	Left Arm ☐ below waist ☐ waist level ☐ chest level Right Arm ☐ 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

Cognitive / Psychological Restrictions / Limitations

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.**

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:

Part 8 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)

Last Name First Name Initial Designation		**Practitioner Number**
Street Address	Phone No.	Fax No.
Town / City	Province	Postal Code
Signature		**Date (mm/dd/yy)**

Attending Physician - Please ensure *Practitioner Number* is entered and the form is **signed and dated**.

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

CONFIDENTIAL LTD FAX # – 306-775-5775

SGEU LONG-TERM DISABILITY PLAN JOB DEMANDS

Employee's Name (Please Print): _____

Job Title (Please Print): _____

Employer (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: _____

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

RELEASE OF INFORMATION

FORM NO. 1

Group Life, Extended Health & Dental

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

Representative

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

Health Care Provider

I hereby authorize and direct that 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. 4.1 (PEPP)

PENSION

I hereby authorize Public Employees' Pension Plan and SGEU Long Term Disability Plan and/or the plan's medical adjudicator to obtain any information regarding my pension contributions and/or status 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.

SGEU LTD Office Use Only:

LTD CLAIM #_____ Date Sent: _____

RELEASE OF INFORMATION

FORM NO. 4.2

MEPP Pension

I hereby authorize the Municipal Employees' Pension Plan and the SGEU Long Term Disability Plan and/or the plan's medical adjudicator to obtain any information regarding my pension contributions and/or status 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.

SGEU LTD Office Use Only:

LTD CLAIM #_____ Date Sent: _____

RELEASE OF INFORMATION

FORM NO. 4.3

SHEPP Pension

I hereby authorize Saskatchewan Healthcare Employees' Pension Plan to provide the SGEU Long Term Disability Plan with a status change notification in the event that I have terminated active enrollment in SHEPP, while I am in receipt of SGEU Long Term Disability 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.

SGEU LTD Office Use Only:

LTD CLAIM #_____ Date Sent: _____

RELEASE OF INFORMATION

FORM NO. 5

WCB

I hereby authorize and direct the SGEU Long Term Disability Plan and/or the Plan's Medical Adjudicator to obtain any information, from Saskatchewan Workers' Compensation Board, regarding my Workers' Compensation Board Application for entitlement and the decision on such application. This will include, but not limited to medical and financial information.

_____
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

EMPLOYMENT

I hereby authorize the release or exchange of any employment-related information including the claim status between my employer **or SGEU Labour Relations Officer** and the SGEU LTD Plan that is required for the purpose of administering my SGEU LTD Plan Long-Term Disability claim.

If information is requested from the employer **or SGEU Labour Relations Officer**, this authorization will allow the SGEU LTD Plan to collect, use and disclose my personal employment information, specifically, any attendance or job performance issues or complaints of workplace conflict or harassment that may have occurred.

_____
Employer

_____
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

SGI

I hereby authorize and direct the SGEU Long Term Disability Plan and/or the Plan's Medical Adjudicator to obtain any information, from Saskatchewan Government Insurance, regarding my Saskatchewan Government Insurance application for entitlement and the decision on such application. This will include, but is not limited to medical and financial information.

_____
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.

Consent Form

FORM NO. 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.