

# Application for Group Long Term Disability Benefits - Employer's Statement

**Important:**

The completed Employer's and Employee's Statements are required before claim assessment can commence. Please ensure they are completed and submitted to Great-West Life at least 8 weeks prior to the end of the Elimination Period. **Benefits may be delayed if this guide is submitted later than 8 weeks prior to the end of the Elimination Period.** Great-West's Privacy Guidelines and applicable law allow claimants to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the claimant.

**A. EMPLOYER IDENTIFICATION**

Name		Group Policy Number	Division Number (if applicable)	Class (if applicable)
Address: Street & Number	P.O. Box	City	Province	Postal code
Telephone Number		Fax Number		

**B. EMPLOYEE IDENTIFICATION**

Name: First	Initial	Last	GWL Employee I.D. Number	Social Insurance Number
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**C. EMPLOYMENT INFORMATION**

Effective date of hire (MM/DD/YY)	Employment Class: Is the Employee:			
	<input type="checkbox"/> Full time: Number of hours worked per week ____		<input type="checkbox"/> Part time: Number of hours worked per week ____	
Last day employee was at work (MM/DD/YY)	<input type="checkbox"/> Temporary	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Permanent	<input type="checkbox"/> Contract
	<input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried	<input type="checkbox"/> Commissioned	
Reason for absence	<input type="checkbox"/> Medical	<input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Strike	<input type="checkbox"/> Dismissed
	<input type="checkbox"/> Quit	<input type="checkbox"/> Retired	<input type="checkbox"/> Other	<input type="checkbox"/> Work related accident or sickness

**Please attach copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.**

Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please indicate date returned (MM/DD/YY)	If no, is a return to work date known?
If yes, please indicate expected date of return (MM/DD/YY)	Has employment terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date (MM/DD/YY)

**D. INSURANCE INFORMATION**

Original effective date of the employee's basic LTD insurance (MM/DD/YY)	Was the employee a late applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date of excess insurance, if any: (MM/DD/YY)
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**E. EARNINGS AND BENEFIT INFORMATION**

**Please answer the following questions. If any do not apply, put N/A in the blank.**

Employee's basic pre-disability monthly earnings (as defined in the contract):	Average monthly commissions earned in the 24 months ending on the last day worked:	TD-1 Claim Code based on personal tax credits:	For Quebec residents, tax deductions according to the latest MR 19:
Date earnings ceased or will cease: (MM/DD/YY)	According to your records: Basic LTD Benefit Amount   Excess LTD Benefit Amount	Is the employee covered for Group Life Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please provide: Group Life Policy Number   Amount of Life Insurance

**For Group Life Insurance, please submit employee enrollment card. If the employee has Optional Life Insurance, please submit a copy of the Optional Life approval letter.**

**DECLARATION**

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

