Employee Guide to

Claiming Disability Benefits

and

Application for Group Short Term Disability Benefits

RWAM DISABILITY MANAGEMENT
A division of RWAM INSURANCE ADMINISTRATORS INC.

Employee Guide to Claiming Disability Benefits

Applying for disability benefits can be confusing. This guide is designed to assist you in this process and to provide answers to the most commonly asked questions. We recommend you (Employee) keep this guide for reference.

How do I qualify for Short Term Disability (STD) benefits?

STD benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury and are paid to you until such time as you can return to work.

To qualify for STD benefits you must be an eligible covered employee, meet the definition of total disability in your group insurance plan, complete an elimination period, and otherwise satisfy the terms of your group STD plan.

Your application for disability benefits does not automatically entitle you to be paid benefits, for reasons that will be stated later in this guide.

How do I claim for STD benefits?

Immediately upon your ceasing work, ensure that all three sections of the attached application are fully completed and submitted to RWAM Disability Management.
Please send by e-mail to: csr-disability@rwam.com, fax to: 519-669-5135, or by mail to: 49 Industrial Drive, Elmira, ON N3B 3B1.

The Employee Statement must be completed in full and signed by yourself; the Employer Statement must be completed by your employer/plan administrator; and the Attending Physician's Statement must be completed and signed by your treating physician. *You are not obligated to share confidential medical information with your employer.* You may submit your completed Employee Statement and Attending Physician Statement sections of the form directly to RWAM Disability Management.

Please ask your doctor to provide as much information as possible in relation to your medical condition such as copies of:

1. Test results (blood work, x-rays, CT scans, psychological testing);
2. Your doctor's office/chart notes;
3. Specialists' consultation reports;
4. Hospital admission and discharge summaries, and operative reports; and
5. All other available information relevant to your claim.

Except where prohibited by law, you are responsible for paying any fees which your doctor may charge for the completion of forms or for providing medical reports.

What if I have applied for Workers Compensation (WCB/WSIB) benefits?

You must still submit your completed disability claim form under your group plan and any other supporting documents to your employer at the same time as you would have, had you not applied to WCB/WSIB. This ensures your claim form is received by us within sufficient time, in the event your Workers Compensation application is denied, or benefits are discontinued.

In most plans, WCB/WSIB benefits must be deducted from disability benefits. If you qualify for WCB/WSIB benefits, please notify our office so we can recalculate your benefit amount. If we have overpaid you, you will need to pay us back.

What happens after I submit my claim for STD benefits?

Your claim will be reviewed as quickly as possible. RWAM confirms that you are an eligible covered employee by verifying that:

- you are enrolled in the group insurance plan;
- premiums have been paid; and
- you were still employed and actively at work immediately before you claimed disability.

Once coverage is confirmed we review all the information submitted, including medical documentation and a description of your job duties, to determine whether you are "Totally Disabled" as defined by your group STD plan.

Your claim will be delayed if insufficient information is provided. In this case we will write to inform you of the delay and we may also ask you to help us obtain more information.

Once your claim is approved, payment along with an explanation of benefits will be sent to you by Electronic Fund Transfer (EFT)/Explanation of Benefits to your personal email.

What can I do to avoid delays in the decision on my claim?

1. Make sure all forms are fully completed and signed.
2. Provide additional details of all factors, both at work and at home, which affect your ability to be at work.
3. Ask your employer to provide your physician and us with your most recent job description and task analysis on each job function.
4. Ask your doctor to include reports from all specialists, results of all testing, and any other medical information. If we do not receive sufficient, clear information, we may be required to write to your physician to obtain the information, resulting in a delay of your claim.
5. Provide copies of any WCB/WSIB, Employment Insurance, CPP/QPP, auto insurance and any other benefit claim records, if you have applied for or are receiving benefits from these other sources.

How and when will I receive my STD benefit payment?

In most cases benefits commence according to the "Payable" day for Sickness, Accident, or Hospitalization as indicated by the STD Schedule of Benefits in your employee booklet.

Benefits are payable to you either weekly or bi-weekly, depending on your group plan. Standard practice is to send payment via Electronic Fund Transfer (EFT) with an Explanation of Benefits being sent by email. Electronic Funds Transfer (EFT) service, which deposits your STD benefits directly into your authorized personal bank account, can take anywhere from 24-48 hours (business days) to be posted to your account.

Payment of benefits cease when:

1. The medical evidence indicates that you are no longer totally disabled; and
2. You have recovered sufficiently to allow you to safely return to work. Depending on your group plan, you may be eligible to receive an adjusted (rehabilitation) benefit if initially you need to return to work part-time under an approved rehabilitation program; and
3. Until you have reached the maximum benefit duration stated in your employee booklet.

Why would I be requested to submit additional medical information once my claim has been approved?

We require periodic updates on your condition and evidence of continuing total disability. In order to obtain this evidence, we may send forms for you and your doctor to complete. In some cases, we may write directly to your physician.

The frequency of these reports will depend on the nature of your condition and the definition of total disability in your group STD plan.

Rehabilitation and a Safe Return to work

If your claim is approved, we may contact you to discuss your return to work. Everyone benefits from your safe and timely return to work. If appropriate, our rehabilitation case manager will work with you, your employer and your physicians to determine and develop the appropriate return to work plan designed just for you.

Why would my claim be denied?

Your claim will be denied if you are not eligible for the coverage, if it is determined that the medical evidence does not support that you are totally disabled, or if you do not otherwise qualify for benefits under the group STD plan.

Research has shown that for certain medical conditions, it is possible and advantageous for people to remain at work while in active treatment and that such an approach can actually shorten the recovery period.

Time taken off work due to the pressure and tension that you may experience in your workplace as a result of factors, such as difficult relationships with co-workers, increased workloads and job demands, actions taken by employers in good faith, such as discipline, work evaluation, transfer, lay-off, demotion or termination are generally regarded as a normal part of the work situation and not as a basis for “total disability” (i.e. unable to work due to illness or injury).

If your claim is denied, RWAM Disability Management will write a confidential letter directly to you and explain the reason(s) for the denial. Your employer will be informed of the status of your claim in a separate letter which excludes any confidential medical reasons.

Privacy

Your employer is entitled to know that you have claimed STD benefits, along with certain basic information such as the status of your claim, your ability to perform your own occupation and any limitations or restrictions your employer needs to know in order to provide you with a safe return to work. It is important that you maintain contact with your workplace during your absence, and the regular communication with your Employer can ease plans for your return to work.

RWAM is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that it collects, uses, retains and discloses in the necessary course of conducting its business. RWAM will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding RWAM’s privacy policies, please refer to your Employee Booklet, ask for a copy of our Privacy brochure, or check our website at www.rwam.com .

Further questions

Consult your employee booklet, including the Schedule of Short Term Disability Benefits and the details provided in the STD section. If you have any questions or if you need help with your claim, please contact your plan administrator or our claims office at 1-877-888-RWAM (7926). Please have your RWAM group number and your personal certificate number ready in order for us to assist you with your inquiry.

Submit to: **RWAM Disability Management**
A division of RWAM Insurance Administrators Inc.
49 Industrial Drive, Elmira, ON N3B 3B1
1-877-888-7926 519-669-1632 fax 519-669-5135
email: csr-disability@rwam.com

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

Employer Statement

(must NOT be completed by claimant)

Please Print

CLAIMANT INFORMATION

Employee's Name ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Male ☐ Female Last Name First Name	RWAM Group #	Division #	Certificate #
Date of Birth (day/month/year) If age 60 or over, a copy of birth certificate must be enclosed with the employee's statement	S.I.N. # (ONLY for taxable plans)		
Address No. and Street - Suite/Apt. No. City/Town Province Postal Code			
Telephone	Email		
Occupation (State occupation held just before employee ceased working)	Briefly describe duties performed (ensure a copy of the job description is attached)		

COVERAGE / RETURN TO WORK INFORMATION

Date of employment (day/month/year)	Date employee became insured for STD coverage **with RWAM** (day/month/year)	Date employee was insured for STD coverage **with a previous carrier** (day/month/year)
☐ Salaried ☐ Full-time ☐ Hourly ☐ Part-time ☐ Contract (attach copy of contract agreement)	Class/Group/Union affiliation to which employee belongs (if applicable)	Regular hours worked per week prior to ceasing work (excluding overtime)

Employee's usual work schedule (ie. Mon-Fri / days / weekends / evenings / night shifts)

Date last worked (day/month/year)	Date: ☐ Returned to work (day/month/year) ☐ Expected to return (day/month/year)	*If applicable*, date employment terminated (day/month/year) (attach details / reasons for termination or lay-off)

Is employee's medical condition due to work-related injury or illness arising out of employment? ☐ Yes ☐ No

If "Yes", has the employee applied for Worker's Compensation Benefits through WCB/WSIB? ☐ Yes ☐ No - If "No", please provide details/reasons

Note: If the employee's illness/injury is claimed to be work-related, an application must be submitted to WCB / WSIB in addition to claiming benefits under this group plan.

Have you discussed a return to work date with your employee? ☐ Yes ☐ No Estimated # of weeks before possible return to work _____ weeks

If "Yes" return to work is planned at: ☐ Own Occupation - ☐ Full-time, date _____ ☐ Part-time, date _____

☐ New Job/Duties - ☐ Full-time, date _____ ☐ Part-time, date _____

If "No" discussion, please explain (attach details if necessary)

EARNINGS / BENEFIT INFORMATION

State current rate of gross earned income $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	Date current rate of gross earned income became effective (day/month/year)	Current personal tax credit per Federal TD1 $ (attach TD1)

Is any portion of the disability premium paid by the policyholder/employer? ☐ Yes (Benefit is Taxable) ☐ No (Benefit is Non-Taxable)

If Non-Taxable benefit, state claimant's current **net** earned income $ (after involuntary tax deductions)

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually (Please attach copy of last pay stub)

Other Income: ☐ Sick Pay ☐ WCB/WSIB benefits ☐ Auto benefits ☐ Gov't EI Sickness benefits ☐ Other _____

Amount $	per	From (day/month/year)	To (day/month/year)

EMPLOYER / GROUP INFORMATION

Name of employer/group	Name of employee's immediate supervisor/manager
Address No. and Street - Suite/Apt. No. City/Town Province Postal Code	
Telephone	Fax	Email

Signature	Competed by: Name	
	Title	
	Date	

Please Print

Employee Name _____

Group # _____ Certificate# _____

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

Employee Statement

EMPLOYEE INFORMATION

Indicate your occupation and briefly describe your duties:		
Your education level - Grade: <6 7 8 9 10 11 12 Post Secondary:		
Describe your present medical condition, its cause and history:		
Date of first treatment for this medical condition (day/month/year)	Medical condition has prevented from working since (day/month/year)	Attempted to return to work? ☐ Yes ☐ No If "Yes", (day/month/year)
Have you ever had a similar injury or illness in the past? ☐ Yes ☐ No If "Yes", describe your condition and the original date of illness or injury:		

List all physicians you have seen for your present medical condition. **Attach copies of all available specialists' reports:**

Physician's Name	Address	Dates Seen From	Dates Seen To	Dates of Hospitalization From	Dates of Hospitalization To	Date of Next Appointment

OTHER BENEFITS INFORMATION

Are you claiming or receiving any other type of disability, wage loss, and/or retirement benefits? ☐ Yes ☐ No

If "Yes", complete the following section. **Attach copies of all correspondence / confirmation of payment(s) you have received from these sources:**

Type of Benefit	Amount	Frequency	Effective Date	Claim No.
☐ WCB / WSIB	$	per		
☐ Auto Insurance	$	per		
☐ EI ☐ Sickness ☐ Unemployment	$	per		
☐ CPP / QPP ☐ Disability ☐ Retirement	$	per		
☐ Other _____ (e.g. legal action)	$	per		

ACCIDENT INFORMATION - Complete only if your medical condition is the result of an accident or injury

Date of accident / injury (day/month/year) Time of accident / injury_____ ☐ A.M. ☐ P.M. Was work being done for an employer at time of accident? ☐ No ☐ Yes

Type of accident: ☐ Work-related ☐ Auto / Motorized vehicle* ☐ Other (e.g. non-work-related fall, cut, etc) _____

Provide accident / injury details:

* If type of accident is auto/motorized vehicle, please detail the events surrounding the accident:

_____

1. Was alcohol involved in the events surrounding the accident? ☐ Yes ☐ No
2. Was the accident reported to police? ☐ Yes ☐ No If "Yes", attach a copy of police report
3. Were any charges laid? ☐ Yes ☐ No If "Yes", against whom? _____
4. Was another party at fault? ☐ Yes ☐ No If "Yes", are you pursuing any legal claim for wage loss or other legal action against the party at fault?
   - ☐ Yes - provide details and/or name of your legal counsel _____
   - ☐ No - give reasons for no legal action _____

CLAIMANT'S AUTHORIZATION AND ASSIGNMENT

In consideration for any payment of disability benefits paid to me by RWAM Insurance Administrators Inc. on behalf of the insurer of my disability plan (the "Payor"), I hereby agree to refund to the Payor, in accordance with the provisions of the applicable group insurance policy/benefit plan document, any monies I may receive from a third party source, as specified by any offset, reduction, all source, or other reimbursement provisions of such plan and that may be owing to the Payor. I further irrevocably assign all right, title and interest of any such monies and any group life insurance proceeds to the Payor for such purposes.

I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person or organization having any relevant medical, employment, vocational, financial or other personal information or records regarding me to release to and exchange with RWAM Insurance Administrators Inc.("RWAM"), or their respective authorized representatives, any and all such information necessary for any or all of the following purposes: to validate my coverage, investigate and confirm the accuracy and validity of my claim, determine my eligibility for benefit payments, administer my claim, assess my ability to return to work and determine/facilitate any approved early intervention program and determine/facilitate any approved rehabilitation/return to work plan and administer the group benefits plan and coverage.

In the event I do not return to work and subsequent to this claim for Short Term Disability (STD) benefits I submit a claim under any Long Term Disability (LTD) benefit plan under which I may be insured, I understand and authorize that a complete copy of my entire STD claim file held by RWAM, will be provided to the LTD insurer and will form part of my LTD claim file for the above named purposes.

I understand that my refusal or withdrawal of this authorization and assignment may delay claim adjudication or result in denial of my claim. I declare that all information provided in this Employee Statement, and any other information I provide with my claim, or statements I make in any personal or telephone interview relating to this claim are/will be true, complete and accurate.

This authorization and assignment shall remain valid for the duration of my claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

_____ Date _____

Employee Signature

Submit to: **RWAM Disability Management**
A division of RWAM Insurance Administrators Inc.
49 Industrial Drive, Elmira, ON N3B 3B1
1-877-888-7926 519-669-1632 fax 519-669-5135
email csr-disability@rwam.com

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

Attending Physician's Statement

(Please answer all questions)

Please Print

PATIENT AUTHORIZATION

Patient Name	Date of Birth	RWAM Group #	Certificate #

I authorize the release of any medical information requested related to my claim for group Short Term Disability benefits to RWAM Insurance Administrators Inc. ("RWAM"). In the event I do not return to work and subsequent to my claim for STD benefits I submit a claim under any Long Term Disability (LTD) benefit plan under which I may be insured, I authorize RWAM to forward all gathered medical information to the LTD insurer.

Patient's Signature ✕ _____ **Date** _____

NOTE: The patient is responsible for obtaining this form and any charges for its completion, except in those provinces governed by statutory regulations.

HISTORY AND DIAGNOSIS

Primary Diagnosis	Secondary Diagnosis

Other contributing factors or complications?

How long have you been treating this patient?

If condition is due to pregnancy, please give expected date of confinement or actual delivery date (day/month/year) ☐ vaginal ☐ c-section

Has patient ever had same or similar condition? ☐ Unknown ☐ Yes ☐ No If "Yes", state *original date* of illness/injury and provide details

PRESENT CONDITION

Date symptoms first appeared or accident happened (day/month/year)	Date medical condition rendered patient unable to work (day/month/year)	Date of first visit for present condition (day/month/year)

Is condition a work-related illness/injury, or arising from employment in any way? ☐ Yes ☐ No If "Yes", please elaborate

SUBJECTIVE AND OBJECTIVE FINDINGS / INVESTIGATIONS

Height	Weight	Blood Pressure	Pulse

Describe physical and/or psychological limitations (e.g. physical restrictions in range of motion; lifting, etc. and/or limitations from depression or other psychological/cognitive problems)

Cardiac (if applicable)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

DSM - 5 Diagnosis (If applicable) (attach copies of chart notes from date of first visit to current date)

Psychotherapy / Counselling (If applicable)

Name of Counsellor _____

Frequency of Sessions _____

Investigations (e.g. EKG's, x-ray, lab tests, etc.)	Date Carried Out	Summary of Results (attach copies of all available reports)

Are any further investigations planned? ☐ Yes ☐ No If "Yes", state type and when

Please attach copies of all chart notes, test results, and consultation reports

cont'd.

Please Print

Patient's Name _____

Group # _____ Certificate# _____

APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS

Attending Physician's Statement

(Please answer all questions)

SUBJECTIVE AND OBJECTIVE FINDINGS / INVESTIGATIONS (cont.d)

Has your patient been referred to any other physician / specialist? ☐ Yes ☐ No If "Yes", please complete the following chart:

Physician's / Specialist's Name	Specialty	Dates of Examinations

Summarize specialist's findings or attach copies of reports

TREATMENT

Since first visit, how often have you seen this patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

Date last treated for condition: Date of next treatment for condition:

List current medications, dosages, and date commenced. Provide reasons for changes to same.

Has patient ever been hospitalized? ☐ Yes ☐ No If "Yes", name of hospital:

Dates of hospitalization - First Stay:

From _____ (Day Month Year) To _____ (Day Month Year)

Dates of hospitalization - Second Stay (if applicable):

From _____ (Day Month Year) To _____ (Day Month Year)

Surgery? ☐ No ☐ Yes If "Yes", state type of surgery _____

Date of surgery _____ (Day Month Year) ☐ Performed ☐ Planned

Physiotherapy? ☐ Yes ☐ No If "Yes", state frequency: ☐ Daily ☐ 3x/week ☐ Weekly ☐ Other _____

Type of physiotherapy ☐ Outpatient/physiotherapy dept. ☐ Independent home exercises

Compliant with treatment program? ☐ Yes ☐ No If "No", reasons?

Any other treatment plans? (specify with dates)

LIMITATIONS

Are you aware of what your patient's job duties are? _____

What major tasks of your patient's occupation is he/she ***able*** to perform?

_____

What major tasks of your patient's occupation is he/she ***unable*** to perform? (please list specifics that impair functional activity)

_____

What activities of daily living are impaired due to this illness and how?

_____

What is being done to return your patient to work?

_____

Patient is ☐ Ambulatory ☐ House confined ☐ Bed confined

PROGNOSIS

Patient is ☐ Recovered ☐ Not improved ☐ Improved ☐ Retrogressed Estimated no. of weeks before possible return to work _____ weeks

Have you discussed a return to work date with your patient? ☐ Yes ☐ No

If "Yes", return to work is planned at: ☐ **Own** Occupation - ☐ Full-time, date _____ ☐ Part-time, date _____

☐ **Other** Occupation - ☐ Full-time, date _____ ☐ Part-time, date _____

If "No" discussion, please explain:

Would vocational counselling and/or retraining be beneficial? ☐ Yes ☐ No - If "Yes", please advise date & comments

ATTENDING PHYSICIAN'S INFORMATION

Name of Attending Physician (please print)

Family Physician? ☐ Yes ☐ No

Specialist? ☐ Yes ☐ No, If 'Yes",specialty is:

Address (No. and Street - Suite/Apt. No. City/Town Province Postal Code)

Telephone	Fax	Email

Physician's Signature ✕ _____ Date _____

Direct Deposit

eSignature option: Certificate of Completion must accompany this form.
Handwritten option: Complete in ink, with any corrections initialed. A copy should be kept for your records and is considered as valid as the original.
Send completed form to: csr-groupadmin@rwam.com or mail to RWAM at address noted below.

Direct Deposit of Group Benefit Payments (otherwise known as Electronic Funds Transfer or 'EFT') allows RWAM to deposit your approved benefit payments directly into your personal or joint bank account (your name must be on the account).

RWAM will email you an Explanation of Benefits (EOB) statement after receiving your submitted claims, indicating the benefit payment and/or decision.

		Group #	Div.	Class	Certificate
Employee	Last Name	First Name			
Personal e-mail address for Explanation of Benefits (EOB)					
Financial Institution					
Address	#, Street	City, Prov.			
Branch/Transit #	5 digits	Financial Institution #	3 digits	Account #	

If account # starts with '0', be sure to include it.
Do not use dashes, hyphens, or any other punctuation.

NOTE:

- If you do not have cheques and are unfamiliar with how to complete the above, contact your financial institution to make sure you are providing RWAM with the correct information.
- Inaccurate or missing information can result in delays or errors.
- You must be the sole or joint (generally jointly with your spouse) account holder at a Canadian financial institution and have signing authority.
- Applications for deposit to a third party's account will not be accepted.
- Paper (non-electronic) submissions can include a Direct Deposit form (obtained from your financial institution) or a cheque marked 'void' to validate account numbers.

AUTHORIZATION

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my personal/joint bank account and to exchange my relevant financial information with my financial institution for such purposes. I authorize correspondence with me through the email address indicated above. I understand such correspondence may contain personal information and that the information is being sent in a manner that is not guaranteed as a secured means of communication. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Signature		Date	

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy, and security of personal information it collects, uses, retains, or exchanges in the necessary conduct of our business.