

Canada Life Group Income Protection

Claim Form

Important

When an employee is absent from work due to an illness, we understand the value of an efficient and timely decision on a claim. We also aim to make the claim process as straightforward as possible, by reducing the amount of paperwork you and your employee need to complete.

By following the guidelines below, and enclosing supportive medical information with the completed claim form, we may be able to speed up a claim decision.

In order to do this:

- Complete the 'Employer' section of this form and Declaration.
- Ask your employee to complete the 'Member' section of the form.
- Send both sections of the form to Canada Life at the same time, enclosing copies of supportive medical information.

Alternatively:

- You may wish to 'split' the form so that your employee can complete the 'Member' section and return it to Canada Life separately.

If you have any questions regarding the completion of the form or the submission process, please call us on **0345 223 8000**.

Please return the completed claim form and medical information to:

**IP Claims Management Services,
Canada Life Limited,
3 Rivergate,
Temple Quay,
Bristol BS1 6ER.**

Canada Life Group Income Protection

Employer section

Employer's details

Employer's name	<input type="text"/>		
Group policy number (if known)	<input type="text"/>		
Employer's head office address	<input type="text"/>		Postcode <input type="text"/>
Employer's contact name	<input type="text"/>		
Telephone number	<input type="text"/>	E-mail address	<input type="text"/>

Employer's bank details

Name and address of the **employer's** bank to which benefit payments should be made if the claim is admitted.

Branch name	<input type="text"/>		
Address	<input type="text"/>		Postcode <input type="text"/>
Account name	<input type="text"/>		
Sort code	<input type="text"/>	Account number	<input type="text"/>

Member's details

Member's surname	<input type="text"/>	Title	<input type="text"/>
Forename(s)	<input type="text"/>		
Previous name(s)	<input type="text"/>		
Address	<input type="text"/>		Postcode <input type="text"/>
Date of birth (day, month, year)	<input type="text"/>	Telephone number	<input type="text"/>
National Insurance number	<input type="text"/>		

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Eligibility details

1 Is the member's normal place of work different from employer's address provided above? Yes No
If 'Yes', please provide details.

2 What was the first date of continuous absence due to incapacity? (day, month, year)

3 What is the member's:
Scheme salary in accordance with insured salary definition? £ Gross Total earnings in 12 months prior to absence? £ Gross
Pensionable salary for calculating pension contributions, if applicable? £ Gross If the member's salary has changed in the last 12 months please state the reason for this and the effective date.

4 When does full payment of full salary cease? (day, month, year)

5 Will the member receive any salary after this date? Yes No
If 'Yes', please provide the amount and dates this will cease.

6 If the member is a partner, please set out full details of the pre and post incapacity remuneration agreement, together with all relevant dates.

7 Is the member included in a pension scheme? Yes No Not covered
If 'Yes', at what rate are pension scheme contributions made? By the employer % By the employee % Date member joined the pension scheme

8 Are the National Insurance contributions contracted in or out? In Out Not covered

9 What other financial benefits does the member currently receive from this employment? Amount p.a.

10 Which of these financial benefits continue in incapacity?

11 Date on which the member first:
Joined the Company's service. (day, month, year) Became eligible for the group income protection scheme. (day, month, year)
Joined the group income protection scheme. (day, month, year)

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Eligibility details (continued)

12 If the member did not join when first eligible, please give reasons why.

13 Is the member still an employee?

Yes No

If 'No', please state reason and date of leaving your employment.

Date of leaving. (day, month, year)

Absence details

1 Nature of illness/incapacity?

2 Details of member's absence history for the 12 months preceding the incapacity.

From - Date (day, month, year)

Reason

To - Date (day, month, year)

From - Date (day, month, year)

Reason

To - Date (day, month, year)

From - Date (day, month, year)

Reason

To - Date (day, month, year)

3 Has the member given any indication that work related issues are involved in the absence?
If 'Yes', please provide details.

Yes No

4 Have there been any disputes or disciplinary action taken against the member prior to absence?
If 'Yes', please provide details.

Yes No

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Occupation details

1	Member's occupation	<input type="text"/>
2	Length of time in role	<input type="text"/> Years <input type="text"/> Months
3	Please provide the member's contracted hours.	<input type="text"/>
4	Please list the activities carried out by the member during their attendance at work.	<input type="text"/>
5	Does the member carry out any work from home? If 'Yes', please clarify the duties/activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
6	In what environmental conditions does the member work?	<input type="text"/>
7	What formal qualifications or license does the member need for their job?	<input type="text"/>
8	Has the member undertaken any part of his/her normal occupation during the deferred period? If 'Yes', please give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
9	Has the member been seen by the company doctor or occupational health adviser? If 'Yes', please give full details, including dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
10	Has a return to work plan been agreed with the member? If 'Yes', please give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>

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Employer Declaration

We, the policyholder, hereby apply for payment of benefit(s) based upon the particulars in Part B and in accordance with the Policy. We declare that the Member was a member of the scheme on the date of last attendance at work and that to the best of our knowledge and belief the particulars set out on the preceding pages are complete and true. (Failure to give complete and true answers could result in the payment of any benefit being refused.)

To be signed by an official of the principal employer

Signature

Date
(day, month, year)

for and on behalf of the Policyholder

Job title

Please tick the box if you do not wish us to contact the member by telephone
(If you do not tick the box we will presume you are happy for us to contact the member.)

Canada Life should be notified as soon as possible if the member returns to active employment.

The Employer and Member sections of the form should be sent together.

Please pass the completed form to your financial adviser or return it direct to:

**IP Claims Management Services,
Canada Life Limited,
3 Rivergate,
Temple Quay,
Bristol BS1 6ER.**

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Member section

Name

Name of the Company
you work for

It may be necessary for us to contact you by telephone as part of our assessment process.

Preferred contact number(s)

E-mail address

Important

If you are the employee, please complete this section of the form and sign the Declaration and Consent.

In order to help us assess the claim as quickly as possible, please enclose copies of letters/correspondence from your doctor or treating specialist.

Frequently asked questions

Why do I have to provide this information?

We require details of the condition/incapacity preventing you from attending work. Letters from your treating doctor or specialist may be sufficient for us to make a prompt decision.

Which information should I provide?

We require confirmation from your treating doctor(s) or medical specialist of your condition/incapacity and any treatment you may have received – or are likely to undergo. This could include any of the following, although this list is not exhaustive:

- Hospital discharge letters following attendance for treatment
- Copies of letters from your treating doctor or specialist following consultations
- Test results or radiography reports
- Correspondence from your General Practitioner relating to your current incapacity

If you wish to keep medical information confidential from your employer, you may wish to pass them your information in a sealed envelope marked **Private and Confidential**. They can forward this to Canada Life on your behalf.

If you are unsure about which information to send, please do not hesitate to call us on 0345 223 8000.

I have no information to provide

Don't worry. This will not affect the claim, but it may take longer to reach a decision. This is because we may need to ask your doctor(s) to provide details of your current state of health.

In some cases, you may be requested to attend a medical examination with a specialist who has not seen you before. Where this is necessary, a specialist as near to your home as possible will be used.

In some cases, we may arrange for a Rehabilitation Consultant to call at your home. They are experienced nurses used to dealing with all aspects of income protection. The Rehabilitation Consultant will always make an appointment in advance and carry proof of identity. If the visit is not convenient, you will be able to make arrangements for a more suitable time.

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Occupation details

1

Have you been able to undertake any part of your normal occupation since the commencement of your present incapacity? If 'Yes', please give details, including dates and nature of the work performed.

Yes No

2

Have you discussed with your employer returning to your normal occupation (full or part time, in a reduced capacity by way of a graded return to work)? If 'Yes', please state the date of the discussions and outcome.

Yes No

3

Have you undertaken any work either paid or unpaid (including voluntary) since the onset of your incapacity? If 'Yes', please give full details.

Yes No

4

Please provide brief details of any previous occupations you have performed, professional qualifications received and training gained.

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Medical details

1 Please describe your illness/incapacity and give the diagnosis (if known) and the date the symptoms started.

2 Please detail any treatment received since the onset of your illness/incapacity.

3 Please list medication received since onset of your illness/incapacity.

4 How do the symptoms of your illness/incapacity prevent you from working?

5 Please state any factors in your workplace that you feel have contributed to this absence.

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Medical details (continued)

6 Name and address of your General Practitioner.

Postcode

Telephone number

Yes No

Name of your specialist

Speciality

Address

Postcode

Telephone number

Date last seen
(day, month, year)

Are you due to see them again? Yes No

If 'Yes',
when?

Name of your second specialist (if applicable)

Speciality

Address

Postcode

Telephone number

Date last seen
(day, month, year)

Are you due to see them again? Yes No

If 'Yes',
when?

Financial details

1 Are you receiving payment, or intending to claim from any other company, society or insurer? (Including pension, credit card protection, mortgage protection and any form of income protection or waiver of premium/contribution). If 'Yes', please give details.

Yes No

Name of provider

Type of policy

Policy number (if known)

Annual amount

 £

Start date (day, month, year)

Duration

Name of provider

Type of policy

Policy number (if known)

Annual amount

 £

Start date (day, month, year)

Duration

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Data Protection Notice

Any personal information provided to Canada Life Limited, (referred to as “Canada Life” in this notice) as data controller will be treated in accordance with the Data Protection Act 1998.

Using personal information

Canada Life uses personal information to undertake any activity relating to its policies, products and services and, where relevant, to process applications, set up and administer policies, products and services and handle any claims.

Given the global nature of Canada Life’s business, it may be necessary to transfer information to countries outside the European Economic Area ‘EEA’ in order to provide Canada Life’s services.

Sharing personal information

Canada Life may share personal information:

- with other Canada Life companies including those outside the EEA;
- with any of its or their service providers, reinsurers and regulators;
- with other insurers and government agencies, including without limitation Her Majesty’s Revenue and Customs ‘HMRC’;

- with other companies, organisations and associations and credit reference agencies in order to prevent, detect or investigate crime;
- for employer-related products and services, with the employer, the trustee(s) and their agents;
- for insurance related products, with your own doctor or relevant medical professionals; and/or
- in any circumstances if permitted or required to do so by law or if Canada Life has consent to do so.

Accessing personal information

A person whose personal information is held by Canada Life has various rights including the right to:

- have any incorrect personal information corrected; and/or
- access the personal information Canada Life holds for which a fee may be charged.

To do so and/or if you need more information, please contact Canada Life at:

Canada Life, Group Insurance, 3 Rivergate, Temple Quay, Bristol BS1 6ER. Telephone 0345 223 8000.

Access to medical reports – your rights

We may need to get medical reports in order to assess this claim in respect of you. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to assess this claim in respect of you.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following.

1 Your current health.

- Any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.

2 Your past health.

- Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
 - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
 - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
 - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue; suicidal thoughts or attempts at suicide; or
 - conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.

3 Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to the Underwriting Manager at Canada Life.

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Member declaration and consent

I confirm that I have answered the questions in this form honestly and have taken reasonable care to ensure those answers are correct.

You should provide the answers on this form personally. If the answers are filled in by anyone else then they must be read over and agreed by you before the declaration is signed. Any amendments or alterations should be completed and initialled by you.

I agree to Canada Life:

- Obtaining relevant information about me, including without limitation, my physical or mental health, lifestyle, occupation duties and potentially hazardous activities from:
 - any medical professional that has attended me;
 - any medical examination or tests that Canada Life arranges;
 - any telephone interview Canada Life arranges;
 - your employer or their agent;
 - other insurers who you have applied to or may cover you for life, critical illness, sickness, disability, accident or private medical insurance.
- Using and sharing my personal information as set out in the Data Protection Notice included on this form.

Please ensure you tick one of the following boxes in respect of your rights under the Access to Medical Reports Act 1988. If you wish to see the report you have 21 days to make arrangements to visit your doctor:

I DO NOT want to see any report from my doctor before it is sent to Canada Life

I DO want to see any report from my doctor before it is sent to Canada Life

If you are submitting this form on behalf of another person, by signing this form you confirm that you have their consent for Canada Life to obtain, use and share their personal information as set out above.

Signature

Date

Our forms are available to download from our website: www.canadalife.co.uk/group

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