

Employee Statement

Short-Term Disability Claim

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for disability benefits under the Canada Post Short-Term Disability Program. **A completed claim form with all relevant and pertinent information must be returned within 7 calendar days of the start of the disability to avoid interruptions in payments.** The completed form should be mailed or faxed directly to:

MORNEAU SHEPELL
50 BURNHAMTHORPE RD W SUITE 316
MISSISSAUGA ON L5B 3C2
Telephone: 1-855-554-3148
Fax: 1-877-562-9126

*This form is not to be used for workplace injuries/illnesses.
 Ask your team leader instead to provide you with the appropriate WCB form.*

SECTION A Employee information (please print)

Employee name (last, first, middle initial):		<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
Full address (street, city, province, postal code):			
Employee ID number:	Email:		
Home phone number:	Alternate phone number:		
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):		

SECTION B Information about your work (please print)

Last day worked (dd/mm/yyyy):	<input type="checkbox"/> Full-time	Team leader's name:
First day of absence (dd/mm/yyyy):	<input type="checkbox"/> Part-time	
Expected return to work:	<input type="checkbox"/> Term employee greater than 6 months	Telephone number:
Job title:	Describe your job duties:	
Do you: <input type="checkbox"/> Work alone <input type="checkbox"/> Interaction with public <input type="checkbox"/> Supervise others <input type="checkbox"/> Drive/operate machinery		

SECTION C Information about your claim (please print)

Is your disability the result of: <input type="checkbox"/> a non-work-related illness? <input type="checkbox"/> a non-work-related accident? <input type="checkbox"/> a motor-vehicle accident?	
Describe how your illness/injury is impacting your abilities:	
Have you had a similar or related condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how long ago?	
Do you feel capable to return to work if modified work is available?	
Date and time of accident (if applicable):	Are you seeking reimbursement from a third party? <input type="checkbox"/> No <input type="checkbox"/> Yes
Briefly describe how and where the accident happened:	
Were you hospitalized or admitted to a clinic (inpatient or outpatient)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name of Institution:	Name of ward/unit:
Date admitted (dd/mm/yyyy):	Date discharged (dd/mm/yyyy):

SECTION D | Income or benefit Information (please print)

Income / Benefit information		Start date	End date	Amount (indicate per week or monthly)
Have you applied for or are you receiving any of the following:	Employment Insurance			
	Benefits payable under any type of Worker's Compensation Board program (WCB / WSIB / CSST)			
	Benefits payable from Motor Vehicle Insurance or other insurance			
	Earnings from other employment (where employment started after last day worked at CPC)			
<i>Note:</i> For the duration of your claim, it is your responsibility to notify Great-West/Morneau Shepell of any work performed, whether or not you have received any wage or remuneration; and any employment income paid to you as a result of work performed by you. The information in Section D will be provided to Canada Post for the purpose of calculating your benefit entitlement.				

SECTION E | Information about your Physician/Health care professional(s)

Name of primary attending physician/health care professional:

Physician's/health care professional speciality (if applicable):	Date first treated for current disability:
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Address:

Telephone number:

Are you following the recommended treatment program? No Yes

Canada Post is subject to the *Privacy Act* and is committed to protecting employee personal information and managing this information with utmost responsibility and care.

You can be sure that any medical information you give to our disability-management providers will be kept strictly confidential and protected from improper and unauthorized use, disclosure, retention and disposal.

I certify that the information on this form is true and complete, to the best of my knowledge. I understand that my claim may be denied or terminated as a result of my providing false, or misleading information, or omitting pertinent information.

I authorize my attending physician/health care professional, Great-West/Morneau Shepell and its agents and service providers and any person or organization who has relevant personal information about me, including health care professionals and organizations, to exchange information for the purpose of determining eligibility for and the adjudication of my claim. This includes the release of any related medical information, including but not limited to copies of all consultation reports, clinical notes, test results and hospital records.

I authorize Great-West/Morneau Shepell and Canada Post to exchange information about me except for details relating to diagnosis, treatment or medication relevant to this claim for the purpose of planning and managing my return to work and for administration of the Short-Term Disability Program.

I agree that a photocopy of this authorization shall be as valid as the original.

Employee's signature: _____ Date (dd/mm/yyyy): _____

NOTE: In the event of an overpayment, Canada Post recover excess amounts paid.