Claim Application Guide for Employees Long Term Disability (LTD)

Pensions and Employee Benefits Division
Department of Human Resources
http://www.gnb.ca/pensions

February 2014

A Claim Application Guide for Employees

Purpose

This is your guide through the application process for Long Term Disability (LTD) Benefits. It will provide you with important information that is intended to help minimize delays in payments due to some common errors or omissions.

Note: This guide is not intended to replace your Benefit Pamphlet, but acts as a supplement to it. For this reason, you will not find information regarding the specific Plan provisions or benefit amounts for which you may be eligible. For a more detailed description of your disability coverage, please refer to the LTD Coverage pamphlet located in the Employee Benefits Folder or visit our website at:

http://www.gnb.ca/pensions

Overview

LTD coverage is a key component of your benefits package. It is designed to provide you with a benefit amount equal to a percentage of your income during periods of prolonged absence from work due to a disability. Your claim will be administered by Medavie Blue Cross (MBC).

The benefit formula is calculated using your gross monthly salary as follows: 60% of the first $2,500 + 50% of the next $2,250 + 40% of the remainder.

Initial Criteria

Before you are eligible to receive benefits, the following criteria must be met:

- Your disability must be medically documented; and currently, you must be under the care of a physician;
- Your illness or injury must span the qualifying period of 4 months; and
- For the 24 months after the qualification period, you must be totally disabled from performing the regular duties of your own **occupation** (not job); and thereafter, from any **occupation** in order to continue to receive benefits.

When to Apply

If it looks as if you will be absent from work for at least 4 months and may require the use of the benefit plan, it is highly recommended that you apply for LTD benefits **within 8-10 weeks following the start of your disability**, regardless of whether or not you will remain on paid sick leave. Should your claim be approved, this will help to ensure you have the financial support you need if recovery takes longer than you or your healthcare professional initially thought.

LTD claim forms must be received at Pensions and Employee Benefits Division (PEBD) within 10 months following the Date of Disability, which is usually the day after your last day worked. If you are entitled to receive benefits under the *Worker's Compensation Act,* a claim (for WOP only) must be received at PEBD within 30 months following the date of disability. The Plan is not liable for benefit payments if a claim is not received within the required timeframe.

Sick Leave

Discuss your accumulated paid sick leave with your Manager. If you have at least 4 months of paid sick leave to cover the qualifying period, premiums will continue to be deducted from your pay through payroll deductions.

If you have been approved for LTD benefits and you have more than 4 months of sick leave credits, you have the option of continuing your paid sick leave OR you may choose to collect the LTD benefit – it's <u>your</u> choice.

If you do not have sufficient paid sick leave to cover the 4-month qualifying period, and you have been approved for a Leave of Absence without pay, you must complete the ***Continuation of Employee Benefits Coverage – Leave of Absence Without Pay / Lay off*** form. Please contact your employer for this form and for further details.

Employment Insurance

If you are not entitled to paid sick leave, or you have exhausted your paid sick leave credits before the LTD benefit begins, consider applying for Employment Insurance (EI) Sickness Benefits. To apply, or for more information on the EI Sickness Benefit, visit the Service Canada webpage:

http://www1.servicecanada.gc.ca/eng/sc/ei/benefits/sickness.shtml

Or call Service Canada, Toll-Free 1-800-206-7218 or TTY 1-800-529-3748.

Waiver of Premium (WOP)

Waiver of Premium (WOP) benefits for LTD allow for the continuation of benefits, free of charge, for a specified period of time. You will be eligible if your claim is approved by MBC, and premiums have been paid during the qualifying period. Shortly after PEBD receives notification from MBC that your claim has been approved, you will receive a letter from PEBD detailing the following information:

- The benefits approved for WOP
- The effective date for benefits approved for WOP
- The maximum WOP benefit period

A new Health & Dental policy number is assigned to employees who are on WOP, but your employee Identification number will remain unchanged. If you are approved for WOP, new identification cards will be mailed to you directly from PEBD. Meanwhile, if you have a drug claim, your pharmacist should be able to locate the new policy number by contacting MBC so that your claim can be processed.

How to Apply

To initiate your claim for LTD benefits, the following forms must be completed and submitted to PEBD:

- ☐ Employee Statement (Form 25-1739); and
- ☐ Attending Physician's Statement (Form 25-1738). Except where prohibited by law, you are responsible for any fees your doctor charges for completion of forms or for providing medical reports.

To ensure confidentiality of your medical information, submit your completed forms directly to PEBD (address below), rather than to your employer.

Your employer will complete the Employer Statement, and send it directly to PEBD along with your job description.

To assist you in the completion of these forms, we have included samples in the pages that follow and have highlighted the areas that most commonly cause delays in claim assessment. The best thing you can do to prevent delays is to ensure that all sections are fully completed.

Contact Information

For questions on:
An active or pending claim – (MBC) 1-877-347-5055
Waiver of Premium – (PEBD) 1-800-561-4012
Pension – (PEBD) 1-800-561-4012
PEBD address:

Postal Address:	Street Address:
PO Box 6000 Fredericton, NB E3B 5H1	Suite 680, York Tower Kings Place, 440 King St. Fredericton, NB E3B 5H8

Important Notes on Completing the Employee Statement

New Nouveau Brunswick

EMPLOYEE STATEMENT – APPLICATION FOR BENEFITS
☐ LONG TERM DISABILITY (LTD) BENEFITS
☐ CONTINUATION OF COVERAGE DURING DISABILITY (WAIVER OF PREMIUM)

Complete and return to: Pensions and Employee Benefits Division (PEBD)
Department of Human Resources, P.O. Box 6000, Fredericton, NB E3B 5H1
Telephone: (506) 453-2296 Toll Free in Canada: 1-800-561-4012 Fax: (506) 457-7388

1. EMPLOYEE INFORMATION (Please Print)

Name (first/last) _____

Sex: ☐ male ☐ female Date of Birth D M Y ➡ **Attach copy of birth certificate.** SIN

Employer (name department, agency, hospital, school district or other) _____ Latest Occupation _____

2. APPLICATION FOR BENEFITS INFORMATION - Please identify which benefits you are claiming.

a) ☐ Long Term Disability (LTD) Benefits

2.b) Remember to complete this section if you are continuing your coverage while disabled. →

b) ☐ Continuation of coverage while disabled - please indicate which plans apply:
- ☐ Accidental Death & Dismemberment Insurance
- ☐ Long Term Disability Plan
- ☐ Basic Life Insurance
- ☐ Supplementary Life Insurance
- ☐ Dependant Life Insurance
- ☐ Health and/or Dental Plans ➡ Policy # _____ Identification # _____ (Located on your Medavie Blue Cross ID card)

c) ☐ Disability Pension (under Teacher's Pension Plan only)

3. INCOME/BENEFIT INFORMATION

Are you receiving salary continuation (paid sick leave, vacation) from your employer? ☐ Yes ☐ No If yes, to what date? (d/m/y) _____

Have you applied for Disability Benefits from the Canada Pension Plan or the Quebec Pension Plan? ☐ Yes ☐ No

Is this claim the result of a work related injury/illness - past or present? ☐ Yes ☐ No

Has a claim been filed under the Worker's Compensation Act? ☐ Yes ☐ No If yes, are benefits payable? ☐ Yes ☐ No ☐ Decision Pending

Is this claim the result of a motor vehicle accident? ☐ Yes ☐ No If yes, is there any legal action involved? ☐ Yes ☐ No

If yes, please provide lawyer's name and address: _____

Are you claiming or receiving salary replacement disability benefits from another group insurance, association or franchise plan? ☐ Yes ☐ No

If yes, name of insurance company: _____ Policy Number: _____

4. MEDICAL CONDITION AND WORK INFORMATION

When did symptoms begin that developed into your present medical condition? _____

From what date has your condition prevented you from working? (d/m/y) _____

Describe your present medical condition, its cause and history. (If you were injured as a result of an accident, describe what happened, when and where it took place.)

_____

_____

_____

_____

Which of your regular job functions could you still fulfill? _____

_____

Which of your regular job functions could you not fulfill? _____

_____

Have you attempted to return to work? ☐ Yes ☐ No If yes check where applicable: ☐ full-time ☐ part-time ☐ regular duties ☐ modified duties ☐ other employer

If no, when do you expect to return to - your regular occupation? (d/m/y) _____ - any other occupation? (d/m/y) _____

25-1739 (1/14)

Page 2

Important Notes on Completing the Employee Statement

Have you previously claimed long-term disability or continuation of coverage benefits under benefit plans for Employees of the Province of N.B.? ☐ Yes ☐ No

Have you had a similar injury or illness in the past? ☐ Yes ☐ No If yes, describe, including original date and if any leave was taken from work: _____

4) Include additional claim details. The more information that is provided, the better your chances of reducing delays caused by requests for more information. →

Please provide any additional information that you believe should be considered in assessing your claim. (Attach additional sheets if needed.) _____

5. MEDICAL INFORMATION

To reduce delays in the assessment of your claim, attach all available test results, consultation reports and hospital discharge summaries - in addition to the Attending Physician Statement Form.

List all Physicians (including any other specialist or health care practitioner) that you have seen for your present medical condition.

Name of Physician/Specialist	Type of Practitioner	Address	Date of 1st visit	Date of next visit	Date(s) of Hospitalization

6. EDUCATION, TRAINING AND EXPERIENCE INFORMATION (Attach copy of current resume or complete information where applicable.)

Highest grade level of education completed _____ Technical/Trade School _____ Type of Diploma obtained _____

College/ University _____ Years completed _____ Type of Diploma obtained _____ Year _____ Major _____

Briefly describe types of employment held in last 15 years: _____

List any technical, administrative or special interest courses taken: _____

List skills acquired in current and previous positions:
(E.g. typing, operation of equipment, supervisory skills, special licenses or designations) _____

Remember to sign and date your claim form!

Optional →

7. If applicable, I hereby authorize release of my name to my union as a Long Term Disability claimant.

Signature of Employee: _____ Date: _____

8. ASSIGNMENT, CERTIFICATION AND AUTHORIZATION (**SIGNATURE REQUIRED**)

I certify that the information in this form is true and complete. I understand the Claims Administrator may investigate this claim. I authorize my employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medically-related facility, insurance company, Worker's Compensation authority, Canada or Quebec Pension Plan, group plan administrator, employer-sponsored pension plan administrator, to release and exchange with the Claims Administrator and the Plan Administrator any medical or benefit payment information to process or manage my claim. I agree that a photocopy of this authorization shall be as valid as the original. I understand that any charges for having forms completed or medical reports are my responsibility.

Required →

Signature of Employee: _____ Date: _____

Address and Postal Code: _____

Tel. No.: _____

25-1739 (1/14)

To avoid delays in the processing of your claim, it is extremely important to ensure all sections are completed in full.

Important Notes on the Attending Physician's Statement

New Nouveau Brunswick

ATTENDING PHYSICIAN'S STATEMENT – APPLICATION FOR BENEFITS
☐ LONG TERM DISABILITY (LTD) BENEFITS
☐ CONTINUATION OF BENEFITS DURING DISABILITY (WAIVER OF PREMIUM)

25-1738(1/14)

Instructions:
1. Please print
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.

Please note:
The patient is responsible for the securing of this form and any charge for its completion.

Part 1: EE must complete this section first and then give to physician for completion. →

PART 1 - PATIENT AUTHORIZATION

Name: _____ Age: _____
(First) (Last)

Social Insurance Number: _____ - _____ - _____ Tel. No.: _____

I hereby authorize the attending/consulting physician and/or health institution/provider to release any information in respect of this claim to my benefits' adjudicators and/or policyholder. I understand that any charges for having this form completed are my responsibility.

Signature: _____ Date _____

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis

Primary: _____ Symptoms _____

Secondary: _____ Symptoms _____

Other contributing factors/complications: _____

2. History

Symptoms began or accident happened on: D M Y

Date of first visit for current condition: D M Y

Work ceased due to illness or injury on: D M Y

Is this a work-related illness/injury? ☐ Yes ☐ No ☐ Unknown

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and provide details:

Relevant medical history? Please explain and give approximate dates. _____

If condition is related to pregnancy, indicate date or expected date of delivery: D M Y

3. Clinical Findings/Investigations

Date of most recent examination of patient: D M Y

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Any fees that the physician may charge for the completion of these forms are the employee's responsibility.

Page 2

Important Notes on the Attending Physician's Statement

This information is critical to the assessment of a claim. If these reports exist and are not included with the initial submission, the assessment of your claim will be delayed by MBC's need to request them.

Cardiac: _____ (if applicable) ☐ Class 1 no limitation ☐ Class 2 slight limitation ☐ Class 3 marked limitation ☐ Class 4 complete limitation

ATTACH ALL COPIES OF CURRENT X-RAYS, EKGS, LABORATORY DATA, CONSULTATION REPORTS, HOSPITAL DISCHARGE SUMMARIES, CLINICAL NOTES, ETC.

Any other investigations planned? ☐ Yes ☐ No If yes, state when and type of investigation _____

Is patient being treated or referred to other physician(s)/specialist(s)? ☐ Yes ☐ No If yes, please complete the following:

Physician's Name & Specialty	Date Patient last seen and next date to be seen

4. General Impression (Describe appearance, development, nutrition, posture, gait, distress, mental alertness, apparent age, etc.)

5. Treatment - Frequency of patient visits: _____ Date of last visit: D M Y

Medications? ☐ Yes ☐ No If yes, please provide details below.

Current medications	Dosage

Surgery? ☐ Yes ☐ No If yes, please provide details below.

Type of Surgery	Date Performed or Date Planned

Hospitalization? ☐ Yes ☐ No If yes, please provide details below.

Admission Date	Discharge Date	Facility	Reason

Therapy? ☐ Yes ☐ No If yes, please provide details below.

Type (e.g. physio, psycho, chiro)	Name of Practitioner

Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No

Any other treatment or future plans for treatment? (Please specify with dates.) _____

Important Notes on the Attending Physician's Statement

Summarize patient's response to treatment: _____

_____

_____

Is patient following recommended treatment? ☐ Yes ☐ No (Please elaborate.) _____

_____

_____

6. Functional Capability - If condition is psychiatric, provide multiaxial assessment, if available.

Is patient: ☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined? Please check box that best describes patient's level of function:

☐ No limitation of functional capacity; capable of normal activity.

☐ Minimal limitation of functional capacity; capable of moderate activity.

☐ Medium limitation of functional capacity; capable of light activity.

☐ Severe limitation of functional capacity; incapable of minimal activity.

Please provide details of any functional limitations/restrictions and provide examples of activity patient is capable of doing:

_____

_____

_____

7. Prognosis & Recovery Factors

Prognosis and timeframe for medical recovery: _____

_____

_____

Other factors affecting recovery? Please explain. _____

_____

_____

Please indicate factors to be considered regarding a return to work plan: _____

_____

_____

_____

8. Remarks

Please provide any additional information or details that may be helpful. _____

_____

_____

_____

Name of Attending Physician _____
(Please print)

Address: _____ Tel.No. ( ) _____ - _____

_____ Fax No. ( ) _____ - _____

Signature: _____ Date: _____

Complete and return to: Pensions and Employee Benefits Division (PEBD)
Department of Human Resources, P.O. Box 6000, Fredericton, NB E3B 5H1
Telephone: (506) 453-2296 Toll Free in Canada: 1-800-561-4012 Fax: (506) 457-7388

Follow up with your physician to ensure the form has been completed and submitted directly to PEBD.