This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within ninety days of the onset of your disability.

1. Notice of Horse-related Accident Claim
   The Notice of Claim asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form.

2. Authorization Request
   The insurer, Canada Life, needs your permission to obtain information that will help them to assess your claim. By signing this authorization request, you give Canada Life permission to obtain this information from Standardbred Canada, your doctor, your employer, other insurers and hospitals where you received treatment.

3. Attending Physician's Report
   Ask your doctor to complete this form and send it to Canada Life. It requests general information about your condition. NOTE - You must complete the first section of this form.

---

**CLAIMS PROCESS**

Two options to submit your claim:

1) Send your complete claim forms to:
   Standardbred Canada
   Attention: Insurance Department
   2150 Meadowvale Blvd.,
   Mississauga, ON L5N 6R6.

2) Send your forms directly to Canada Life:
   East Toronto DMSO
   600 – 1315 Pickering Parkway
   Pickering, ON L1V 7G5
   Fax: 1 888 214-4401
   Em: EastTorontoDMSO@canadalife.com

Standardbred Canada will confirm your membership and licence status.

Canada Life will assess your claim when it receives these completed forms from you, your doctor and Standardbred Canada. Canada Life will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

**PROCEDURE DE PRÉSENTATION DE VOTRE DEMANDE**

Présentez votre demande à :
   Standardbred Canada
   À l’attention du : Service des assurances
   2150 Meadowvale Blvd.,
   Mississauga, ON L5N 6R6.

Envoyez vos formulaires directement à Canada Vie :
   East Toronto DMSO
   600 – 1315 Pickering Parkway
   Pickering, ON L1V 7G5
   Fax: 1 888 214-4401
   Em: EastTorontoDMSO@canadalife.com

Standardbred Canada confirmera votre statut de membre et votre type de licence et fera suivre les documents dûment remplis à la Canada Vie.

La Canada Vie évaluera votre réclamation dès réception des formulaires dûment remplis par vous, votre médecin et Standardbred Canada. Si vous êtes admissible à des prestations d’invalidité, la Canada Vie vous communiquera sa décision le plus tôt possible et vous expliquera les restrictions applicables, le cas échéant.

Note: Tant que vous toucherez des prestations d’invalidité, vous êtes tenu d’informer la Canada Vie de tout travail exécuté et relié à l’industrie des chevaux en contrepartie ou non d’un salaire ou d’une rémunération, ou de tout revenu d’emploi qui vous a été versé, ou a été versé à une autre personne ou à un tiers, en contrepartie d’un travail que vous avez accompli dans l’industrie des chevaux.
<table>
<thead>
<tr>
<th>Member Name</th>
<th>Licence</th>
<th>Date</th>
<th>YYY</th>
<th>MM</th>
<th>DD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Active Driver
- Active Trainer
- Groom
- Official
- Report of Driver/Trainer Race Dates attached
- Claim #

- Age
- Province
- Accident

- Male
- Female

- Track
- Farm

- Claim received
- Claim submitted to GWL
- Claim paid to

_____ weeks paid in last four years
_____ weeks paid this claim

Signature
### HORSE-RELATED EMPLOYMENT

- **If you are self-employed,** answer Section A & C. If you are employed by someone else, answer Section B & C.

#### EMPLOI RELIÉ À L'INDUSTRIE DES CHEVAUX

- **Si vous êtes un travailleur indépendant,** remplissez les Sections A & C. Si vous travaillez pour le compte de quelqu'un d'autre, remplissez les Sections B & C.

#### Section A – Self employed

(Answer all questions if applicable.)

<table>
<thead>
<tr>
<th>Name of horse / Nom du cheval</th>
<th>Age</th>
<th>Name of horse / Nom du cheval</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of horses you train for yourself / Nom des chevaux que vous entraînez à votre compte**

**Name of horses you train for someone else / Nom des chevaux que vous entraînez pour quelqu'un d'autre**

<table>
<thead>
<tr>
<th>Name of horse / Nom du cheval</th>
<th>Age</th>
<th>Name of owner / Nom du propriétaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section B – Employed by someone else

<table>
<thead>
<tr>
<th>Name of Employer / Nom de l'employeur</th>
<th>Address of Employer / Son adresse</th>
<th>Employer’s Telephone / Téléphone de l’employeur</th>
<th>Weekly Earnings / Gains hebdomadaires $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>( )</td>
<td>-</td>
</tr>
</tbody>
</table>

**How long employed? / À son emploi depuis combien de temps?**

**Years/Années / Months/Mois**

<table>
<thead>
<tr>
<th>Have you applied for or are you receiving the following / Avez-vous demandé ou recevez-vous les revenus suivants:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Canada/Quebec Pension Plan / Prestations du RPC ou du RQG</td>
</tr>
<tr>
<td>- Worker's Compensation Board Benefits (or similar plan) / Prestations en vertu d'une loi sur les accidents de travail</td>
</tr>
<tr>
<td>- Automobile Insurance Benefits / Indemnité d'une assurance automobile</td>
</tr>
<tr>
<td>- Horse-related Employment Income / Autre revenu provenant d'un emploi relié à l'industrie des chevaux</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I have applied / J'ai demandé</th>
<th>I am receiving / Je reçois</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/Oui No/Non</td>
<td>Yes/Oui No/Non</td>
</tr>
</tbody>
</table>

#### Other revenue

<table>
<thead>
<tr>
<th>Other type of income / Autre source de revenus</th>
<th>Amount / Montant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>($ )</td>
</tr>
<tr>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

**Signature**

Date
Your consent

Before we can process your claim for benefits, you must read this agreement and sign in the signature box below.

Sharing your personal information

We collect, use and disclose your personal information to:

• investigate and assess your claim
• administer your claim and the group benefits plan
• work out a rehabilitation plan to get you back to work
• audit the assessment of the claim
• manage internal data for analytics purposes

We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

• Healthcare and rehabilitation providers
• Insurance and reinsurance companies
• Administrators of the plan, of government benefits and of other benefit programs
• Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
• Your employer’s occupational health services
• Your union representative
• Service providers and other organizations working with us, or on behalf of the other parties mentioned above. We may use service providers outside Canada.
• An auditor authorized by us, your employer, plan sponsor or their agent

Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we’ve authorized. The only persons with access to the information are:

• people working at Canada Life and those we’ve authorized, who need the information to do their jobs and manage your claim
• those whom you’ve given access
• those authorized by law both within Canada and in any other jurisdiction where your personal information is held.

For a copy of our Privacy Guidelines see canadalife.com or you can write to Canada Life’s Chief Compliance Officer.

By signing below, you confirm that:

✓ You have read, understand and agree with the contents of this form and authorize us to collect and disclose your personal information.
✓ Except for audit purposes, your authorization is valid for the duration of your claim or until you cancel it in writing.
✓ All statements you have made about your claim are true and complete
✓ A photocopy or electronic copy of this authorization is as valid as the original.

Your group plan number | Your Canada Life ID number | Date (mm/dd/yyyy)
-------------------------------|-----------------------------|--------------------------
Telephone Number | Email Address | Enter your email address if you would like Canada Life to communicate with you by secure email about your disability claim.

Your name (please print) | Signature
-------------------------------|-----------------------------

canadalife.com • 1-855-755-6729
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### Attending Physician’s Statement - Short Term Disability Claim/Early Referral Services

#### Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

<table>
<thead>
<tr>
<th>Plan Member/Employee Name (Last, First, Middle Initial)</th>
<th>Home Phone # (+ Area Code)</th>
<th>Cell Phone # (+ Area Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, Province, Postal Code)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer’s Name</th>
<th>Group Plan Number</th>
<th>Canada Life Employee Identification Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Date of Birth (dd/mm/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last Date Worked (dd/mm/yyyy)</th>
<th>Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy)</th>
</tr>
</thead>
</table>

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life for the purposes stated above. I acknowledge that my consent enables Canada Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

**TO BE COMPLETED BY THE PHYSICIAN (or Nurse Practitioner Where Applicable)**

#### STOP

- If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete **Page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.

**PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE**

### Primary Diagnosis:

[ ]

### Secondary and/or Complications:

[ ]

### If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) [ ] Vaginal [ ] C-Section

### Occupational Illness/injury

- Yes [ ] No [ ]

- If yes, date of event: (dd/mm/yyyy)

### Auto Accident

- Yes [ ] No [ ]

- If yes, date of event: (dd/mm/yyyy)

### Date of first visit to you pertaining to this condition: (dd/mm/yyyy)

### First date of work absence due to condition: (dd/mm/yyyy)

### Hospitalization

- Is/was patient hospitalized [ ] or had day surgery [ ]

- Date of admittance (dd/mm/yyyy):

- Date of discharge (dd/mm/yyyy):

- Institution Name:

### If surgery was performed please provide date and description of surgery:

- Date (dd/mm/yyyy):

- Description:

### Treatment (drug, dosage, physiotherapy, other):

[ ]

### Prognosis

Please provide the prognosis for recovery:

[ ]
Continuation of Attending Physician’s Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes □ No □
If yes, date (dd/mm/yyyy): _____________________________ Treatment Provider: _____________________________

Please describe the patient’s symptoms including history, severity and frequency:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Frequency of Visits: □ Weekly □ Monthly □ Other _____________________________

Please attach copies of all relevant:
• test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
• consultation reports
• do not provide genetic test results

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

Name of Specialist: _____________________________ Specialty: _____________________________ Date of Visit: _____________________________

Based on your clinical findings and observations, please describe the patient’s current cognitive and/or physical functional abilities.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list any complications and additional conditions impacting your patient’s level of function or the expected recovery period.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is the patient following the recommended treatment program? Yes □ No □

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

________________________________________________________________________
________________________________________________________________________

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print) Certified Specialty Physician’s Stamp

Address (Street, City, Province, Postal Code)

Telephone # (+ Area Code) Fax # (+ Area Code)

Email Address

Signature Date Signed (dd/mm/yyyy)