



Short Term Disability Income Benefits For Horse – Related Accident

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.

Assurance invalidité de courte durée - Accidents liés à l’industrie des chevaux

Le présent guide contient les formulaires à remplir pour demander des prestations d’invalidité, et certains renseignements importants sur le règlement des demandes.

Ces formulaires doivent être présentés dans les 90 jours suivant le début de l’invalidité.

1. Déclaration d’accident

La déclaration d’accident contient les renseignements généraux sur vous, votre travail et la nature de votre invalidité nécessaires à l’évaluation de votre demande. Veuillez répondre à toutes les questions.

2. Demande d’autorisation

Nous avons besoin de votre permission pour obtenir les renseignements qui nous aideront dans l’évaluation de votre demande. En signant ce formulaire, vous autorisez la Canada Vie à obtenir ces renseignements de Standardbred Canada, votre médecin, votre employeur, d’autres assureurs et hôpitaux où vous avez reçu des soins.

3. Déclaration du médecin traitant

Demandez à votre médecin de remplir ce formulaire donnant les renseignements généraux sur votre état de santé. REMARQUE - Vous devez remplir la première section de ce formulaire.

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.

Note: For the duration of your claim for benefits, it is your responsibility to notify Canada Life of any horse-related work performed, whether or not you have received a wage or remuneration, or any employment income paid to you or any other person or party as a result of work performed by you in the horse industry.

PROCÉDURE 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.

FOR OFFICE USE ONLY

Member Name

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

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

Signature _____

Member #	Date	YYYY	MM	DD
Licence	Birth			
Age	Last Renewal			
Province	Accident			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Claim received			
<input type="checkbox"/> Track <input type="checkbox"/> Farm	Claim submitted to GWL			
	Claim paid to			

**NOTICE OF HORSE-RELATED ACCIDENT CLAIM
 DÉCLARATION D'ACCIDENT RELIÉ À L'INDUSTRIE DES CHEVAUX**

#33337

Last Name/ Nom de famille		Given Name/ Prénom		Membership No./ No. d'adhérent	Date of Birth / Date de Naissance Year/ Année Month/ Mois Day/ Jour			
Address/ Adresse		City/ Ville	Province	Postal Code/Code postal		Telephone (Res.) / Téléphone (résidence) () -		
Licence Category Catégorie de licence		<input type="checkbox"/> Driver Conducteur	<input type="checkbox"/> Trainer Entraîneur	<input type="checkbox"/> Groom Palefrenier	<input type="checkbox"/> Official Officiel			Telephone (Bus.) / Téléphone (bureau) () -
Do you regularly work within Horse Industry? Travaillez-vous régulièrement pour le compte de l'industrie des chevaux?			<input type="checkbox"/> Year-round / À l'année <input type="checkbox"/> Seasonal / Saisonnier		How many hours do you normally work each week within the horse industry? Combien d'heures travaillez-vous pendant une semaine normale dans l'industrie des chevaux? _____ Hours/Heures			
What are your normal duties? En quoi consistent vos tâches normales? _____								
Are you employed elsewhere outside Horse Industry? / Travaillez-vous ailleurs que dans l'industrie des chevaux? <input type="checkbox"/> Yes / Oui <input type="checkbox"/> No / Non <input type="checkbox"/> Full-time / Temps plein <input type="checkbox"/> Part-time / Temps partiel				Are you self-employed outside Horse Industry? / Êtes-vous un travailleur indépendant pour le compte d'une autre industrie? <input type="checkbox"/> Yes, what industry? Oui. Laquelle? <input type="checkbox"/> No/ Non				
If yes, give name of Employer/ Dans l'affirmative, indiquez le nom de cet employeur.				Position/ Fonction				

Date of Accident / Date de l'accident	Year/Année	Month/Mois	Day/Jour
Date you last worked before your accident / Date de votre dernière journée travaillée précédant l'accident.			
When do you expect to return to work? / Quand prévoyez-vous retourner au travail?			

Where did the accident take place? Où l'accident est-il arrivé?	Name of horse(s) involved in the accident Nom du/des chevaux impliqué(s) dans l'accident
What injuries did you receive? Décrivez la nature de vos blessures. _____	

Describe how the accident happened (use additional paper if necessary.)
 Décrivez les circonstances de l'accident. (Si nécessaire, utilisez une feuille séparée.)

Give name and address of any witnesses to the accident. Donnez les nom et adresse de toute personne ayant été témoin de l'accident :		
Name / Nom	Address / Adresse	Telephone / Téléphone
1)		() -
2)		() -

**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.**

A Section A – Self employed (Answer all questions if applicable.) Section A – Indépendant (Répondez à toutes les questions pertinentes.)				B Section B – Employed by someone else Section B – À l'emploi de quelqu'un d'autre			
Name of horses you train for yourself / Nom des chevaux que vous entraînez à votre compte				Name of Employer Nom de l'employeur			
Name of horse / Nom du cheval	Age	Name of horse / Nom du cheval	Age	Address of Employer Son adresse			
1)		2)		Employer's Telephone / Téléphone de l'employeur			
Name of horses you train for someone else Nom des chevaux que vous entraînez pour quelqu'un d'autre				() -		Weekly Earnings Gains hebdomadaires \$	
Name of horse / Nom du cheval	Age	Name of owner / Nom du propriétaire					
1)				How long employed? À son emploi depuis combien de temps? _____ Years/Années _____ Months/Mois			
2)							
Have you applied for, or are you receiving the following: Avez-vous demandé ou recevez-vous l'un des revenus suivants :				I have applied J'ai demandé	I am receiving Je reçois	Amount	
- Canada/Quebec Pension Plan / Prestations du RPC ou du RRQ				Yes/Oui	No/Non		
- Worker's Compensation Board Benefits (or similar plan) / Prestations en vertu d'une loi sur les accidents de travail							
- Automobile Insurance Benefits / Indemnité d'une assurance automobile							
- Horse-related Employment Income / Autre revenu provenant d'un emploi relié à l'industrie des chevaux							

Signature _____ Date _____



Group disability privacy disclosure



At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your [online account](#) or by submitting a request through our [privacy centre](#) at canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit canadalife.com/privacy.



Your consent

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

We collect, use and disclose your personal information to:

- Investigate and assess your claim(s) under the group benefits plan
- 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 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

- ✓ I have read, understand and agree with the contents of this form and authorize Canada Life to collect and exchange my personal information.
- ✓ I understand that my personal information will be collected, used and shared as set out above.
- ✓ Except for audit purposes, my authorization is valid for the duration of my claim or until I cancel it in writing.
- ✓ All statements I have made about my claim are true and complete.
- ✓ A photocopy or electronic copy of this authorization is as valid as the original.

Date of birth (mm/dd/yyyy)	Telephone Number	Date signed (mm/dd/yyyy)
Your name (please print)	Signature 	
Enter your email address if you would like Canada Life to communicate with you by secure email.		

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT			
Plan Member/Employee Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name		Group Plan Number	Canada Life Employee Identification Number
Height	Weight	Date of Birth (dd/mm/yyyy)	
Last Date Worked		Date Returned to Work or Expected Return to Work Date	
(dd/mm/yyyy) _____		(dd/mm/yyyy) _____	
<p>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.</p> <p>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).</p> <p>This consent may be revoked by me at any time by sending a written instruction.</p> <p>I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.</p>			
_____ Plan Member/Employee Signature		_____ Date of Consent (dd/mm/yyyy)	
TO BE COMPLETED BY THE PHYSICIAN (or Nurse Practitioner Where Applicable)			
STOP	<ul style="list-style-type: none"> • 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 <input type="checkbox"/> C-Section <input type="checkbox"/>	
Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____		Auto Accident Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> or had day surgery <input type="checkbox"/> 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)	