THE Great-West Life ASSURANCE COMPANY

Claim for Group Weekly Indemnity Benefits

Ford Group Health Programs Trust
Ford Motor Company of Canada, Limited

Please complete all sections and sign.

Group No.	Division No.	Social Insurance Number	Dept./Zone	Seniority Date (Month / Day / Year)	Classification
382 55028					

Employee's Statement

Surname (Please Print) | Given Names

Address | Apartment

City | Province

Postal Code | Phone Number

Date of Birth (Month / Day / Year)

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married

Job / Describe duties briefly

Base hourly rate	Date last worked (Month / Day / Year)	Starting time	Number of hours worked	Date you first became totally disabled (Month / Day / Year)	If no longer disabled, give date you were first able to return to work (Month / Day / Year)
$		☐ a.m. ☐ p.m. at o'clock			

Accident Information - complete only if claim is the result of an accident

Date of accident (Month / Day / Year) | Time of accident: at o'clock | Was work being done for an employer at time of accident? ☐ Yes ☐ No

Particulars of accident including location

Direct Deposit

Please deposit my disability payments to the following account:

☐ Savings account (consult your bank for the proper bank identification number) ☐ Chequing account (attach sample cheque marked "void")

PLEASE PRINT

Name of bank, trust co., credit union, etc.	Bank #	Transit #	Account #
Branch address	Name of account holder		
City/Town, Province / Postal code	**NOTE: for Canadian institutions only**		

Authorizations and Declarations

Protecting Your Personal Information

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect every individual's right to privacy. Personal information about you is kept in confidential files at the offices of Great-West Life or in the offices of an organization authorized by Great-West Life. This information about you may include contact information, cause of disability, treatment and medications and other medical or psychiatric information. We limit access to information in your files to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. The information is used to establish your entitlement, investigate or assess your claim, underwrite, administer or adjudicate claims under the group benefits plan, perform independent medical assessments, audit the group benefits plan, assist in rehabilitation or return to work planning, and administer the group benefits plan (the "Purposes").

I declare that I have read and I understand and agree with the contents of the box above entitled "Protecting Your Personal Information".

I certify that the statements in this form are true and complete and authorize:

- Great-West, third parties acting on its behalf, and reinsurers to collect, use and disclose my personal information as needed to fulfill the Purposes set out in the box entitled "Protecting Your Personal Information", above;
- For these Purposes, any health professional or rehabilitation provider, investigative agency, other insurance/reinsurance companies, administrators of government benefits, and any other organizations and individuals having relevant information to provide such information to Great-West and Great-West to provide relevant information to such parties;
- For these Purposes, Great-West to provide my personal information to my employer and my employer to provide my personal information to Great-West, provided that details regardng my diagnosis, treatment or medication will only be provided to physicians designated by my employer, except where necessary in the course of legal actions, appeals, arbitration hearings or the Informal Procedure for Review of Claims. Only those persons who need to access my personal information to carry out their duties in furtherance of the Purposes will have access to such personal information.

My consent is given freely and a copy of this authorization is as valid as the original.

Date _____ Year _____ Signature _____

Employer's Statement

Effective Date (Month / Day / Year)	Employee weekly indemnity benefit	Actual date last worked (Month / Day / Year)	Date returned to work (Month / Day / Year)	If coverage for this employee has terminated, give date and reason (Month / Day / Year)

Is this disability a Workers' Compensation Claim (WCB)? ☐ Yes ☐ No

Is employee eligible for a company paid holiday? ☐ Yes ☐ No

Date of holiday: (Month / Day / Year)

Has claim been reported to the Workers' Compensation Board? ☐ Yes ☐ No
(in Quebec: Commission de la santé et de la securité du travail du Québec)

Have you any reason to question the validity or length of this claim? ☐ Yes ☐ No

If "yes", please explain. _____

Show the Total Tax Exemptions: Provincial exemptions: $ _____ (dollar amount) **Federal exemptions:** $ _____ (dollar amount)

Please indicate the following amounts you deducted from your payroll system based on wages you paid:

Employee CPP contributions deducted year to date:	Employee QPP contributions deducted year to date:	Employee EI premiums deducted year to date:	Employee QPIP premiums deducted year to date:
$	$	$	$

Employee year to date pensionable earnings: $ _____

Employee year to date insurable earnings: $ _____

Date _____

Administrator

Signature of Authorized Official — Title

M5875-6/12

Attending Physician's Statement

Instructions
1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility

Part 1: Patient Authorization

Name | Date of birth (day, month, year)

I hereby authorize the release to The Great-West Life Assurance Company, the claims paying agent, and my employer of any information in respect of this claim.

Patient's Signature | Date (day, month, year)

Part 2: Attending Physician's Statement

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened

   b) has patient had same or similar condition? ☐ No ☐ Yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

4. If patient is/was pregnant indicate date or expected day of confinement. (day, month, year)

5. Date of hospital in-patient admission (day, month, year) Date of discharge (day, month, year)

6. Nature of treatment (e.g. date and type of surgery)

7. a) If patient was referred to you, give name of referring physician

   b) If you have referred patient to a specialist, give name(s) of physicians

8. a) Date of first visit during present period of absence from work (day, month, year)

   b) Date of latest attendance (day, month, year)

   c) Were you actively supervising this patent's care during the full period?
   ☐ No, comment in remarks
   ☐ Yes, state frequency of visits Weekly Monthly Other (specify)

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition

   From (day, month, year) _____ To (day, month, year) _____ inclusive.

   b) If still unable to work, give approximate date patient should be able to return (day, month, year) _____

   or the estimated number of weeks before possible return _____

10. Please advise how present condition affects patient's ability to work (for example, restrictions, limitations, proposed surgery, etc.)?

11. Remarks – please provide comments and further details which you feel would be helpful.

Name of attending physician | Specialty | Telephone no. ( )

Address (number, street, city, province, postal code)

Signature | Date (day, month, year)

Clear