Employee Statement

Extended Disability Program

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 Extended Disability Benefit Program. The completed form should be mailed or faxed directly to

GREAT-WEST/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):	☐ Mr. ☐ Ms.
Full address (street, city, province, postal code):	
Employee ID number:	Email:
Home phone number:	Alternative phone number:
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):

SECTION B 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			
	Other			

Note: 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.

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 the disability-management provider 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 doctor, 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 Extended Disability Benefit Program 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 Extended Disability Benefit 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 will recover excess amounts paid.