STANDARDBRED CANADA
2150 Meadowvale Blvd.,
Mississauga, Ontario L5N 6R6
Tel: 905-858-3060 Fax: 905-858-3111
Website: www.standardbredcanada.ca

#33337

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 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.

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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			
☐ Male ☐ Female		Claim received			
☐ Track ☐ 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) ( ) -
				Telephone (Bus.) / Téléphone (bureau) ( ) -

Licence Category / Catégorie de licence: ☐ Driver / Conducteur ☐ Trainer / Entraîneur ☐ Groom / Palefrenier ☐ Official / Officiel

Do you regularly work within Horse Industry? / Travaillez-vous régulièrement pour le compte de l'industrie des chevaux? ☐ Year-round / À l'année ☐ 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?
☐ Yes / Oui ☐ No / Non ☐ Full-time / Temps plein ☐ Part-time / Temps partiel

If yes, give name of Employer/ Dans l'affirmative, indiquez le nom de cet employeur. | Position/ Fonction

Are you self-employed outside Horse Industry? / Êtes-vous un travailleur indépendant pour le compte d'une autre industrie?
☐ Yes, what industry? / Oui. Laquelle? _____
☐ No/ Non

	Year/Année	Month/Mois	Day/Jour
Date of Accident / Date de l'accident			
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.)

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

Name of horse / Nom du cheval	Age	Name of horse / Nom du cheval	Age
1)		2)	

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

Name of horse / Nom du cheval	Age	Name of owner / Nom du propriétaire
1)		
2)		

B Section B – Employed by someone else / Section B – À l'emploi de quelqu'un d'autre

Name of Employer / Nom de l'employeur

Address of Employer / Son adresse

Employer's Telephone / Téléphone de l'employeur ( ) -

Weekly Earnings / Gains hebdomadaires $

How long employed? / À son emploi depuis combien de temps? _____ Years/Années _____ Months/Mois

C

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 Yes/Oui	No/Non	I am receiving / Je reçois Yes/Oui	No/Non	Amount / Montant
- Canada/Quebec Pension Plan / Prestations du RPC ou du RRQ					
- 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 _____

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 X	

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The patient is responsible for any fees related to the completion of this form.

CLHIA ACCAP

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 (dd/mm/yyyy) _____	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy) _____

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.

_____ _____

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

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:

_____

_____

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CLHIA ACCAP

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)	