CANADA POSTES / POST CANADA
From anywhere... to anyone

Employee Statement

Short-Term Disability Program Claim

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 Short-Term Disability Program. A completed claim form with all relevant and pertinent information must be returned within 14 days of the start of the disability to avoid interruptions in payments. 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 Information about your work (please print)

Last day worked (dd/mm/yyyy):	☐ Full-time	Team leader's name:
First day of absence (dd/mm/yyyy):	☐ Part-time	
Expected return to work:	☐ Term employee greater than 6 months	Telephone number:
Job title:	Describe your job duties: _____	
Do you: ☐ Work alone ☐ Interaction with public ☐ Supervise others ☐ Required to drive/operate machinery	_____	

SECTION C Information about your claim (please print)

Is your disability the result of: ☐ a non-work-related illness? ☐ a non-work-related accident? ☐ a motor-vehicle accident?

Describe how your illness/injury is impacting your abilities:

Have you had a similar or related condition? ☐ **No** ☐ **Yes** If yes, how long ago?

Do you feel capable to return to work if modified work is available?

Date and time of accident (if applicable):	Are you seeking reimbursement from a third party? ☐ **No** ☐ **Yes**

Briefly describe how and where the accident happened:

Were you hospitalized? ☐ **No** ☐ **Yes** Name of Institution:

Name of ward/unit:

Date admitted (dd/mm/yyyy): Date discharged (dd/mm/yyyy):

SECTION D Income or benefit Information (please print)

Income / Benefit information Have you applied for or are you receiving any of the following:		Start date	End date	Amount (indicate per week or monthly)
	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.			

SECTION E Information about your Physician/Healthcare professional(s)

Name of primary attending physician/health care professional:

Physician's speciality (if applicable):	Date first treated for current disability:

Address:

Telephone number:

Are you following the recommended treatment program? ☐ **No** ☐ **Yes**

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 our disability-management providers 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/healthcare professional, Great-West/Morneau Shepell and its agents and service providers and any person or organization who has relevant personal information about me, including healthcare professionals and organizations, to exchange information for the purpose of determining eligibility for and the adjudication of my 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 Short-Term Disability 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.