THE Great-West Life ASSURANCE COMPANY

CANUS, UNICARE - Policy 106269
LONG TERM DISABILITY
EMPLOYER'S REPORT OF CLAIM

Great-West Life your Benefits Solutions People

CLAIMANT

1. EMPLOYEE'S NAME		2. SOCIAL SECURITY NUMBER		3. DATE OF BIRTH
4. ADDRESS	CITY	STATE	ZIP CODE	5. PHONE NUMBER
6. EMPLOYEE DATE OF HIRE	7. EFFECTIVE DATE OF LTD		8. DATE EMPLOYEE LAST WORKED FULL TIME	

EMPLOYMENT

9. OCCUPATION AT THE TIME LAST WORKED (ATTACH JOB DESCRIPTION)

10. WORK SCHEDULE AT TIME LAST WORKED

NO. OF DAYS PER WEEK _____ NO. OF HOURS PER DAY _____

11. REASON FOR LEAVING WORK

☐ SICKNESS ☐ GRANTED LOA ☐ LAID OFF
☐ RETIRED ☐ DISMISSED ☐ OTHER
☐ RESIGNED ☐ VACATION

12. HAS THE EMPLOYEE RETURNED TO WORK?

☐ YES ☐ PART-TIME ☐ FULL-TIME
☐ NO DATE _____ DATE _____

INCOME

13. HOW IS EMPLOYEE PAID?

☐ STRAIGHT SALARY ☐ HOURLY
☐ SALARY & COMMISSIONS ☐ SALARY & BONUS ☐ COMMISSIONS ONLY

14. EMPLOYEE'S BASIC MONTHLY EARNINGS

$_____ LTD BENEFIT _____

IF SALARY IS BASED ON LESS THAN 12 MOS. - NO. OF MOS. _____

15. EMPLOYEE'S PERCENT OF LTD PREMIUM CONTRIBUTION

EMPLOYEE PAYS _____% ☐ PRE-TAX ☐ POST-TAX EMPLOYER PAYS _____%

OTHER BENEFITS

16. HAS INSURED RECEIVED OTHER DISABILITY PAYMENTS SINCE TIME LAST WORKED?

SALARY CONTINUANCE:	SHORT TERM:	OTHER TYPE: _____
☐ YES (WEEKLY AMOUNT) _____	☐ YES (WEEKLY AMOUNT) _____	☐ YES (WEEKLY AMOUNT) _____
DATE BENEFITS CEASE _____	DATE BENEFITS CEASE _____	DATE BENEFITS CEASE _____
☐ NO	☐ NO	☐ NO

17. DID CLAIM RESULT FROM JOB ACTIVITY? ☐ YES ☐ NO

18. HAS WORKERS' COMPENSATION CLAIM BEEN FILED? (INCLUDE COPY OF 1ST REPORT OF ACCIDENT) ☐ YES ☐ PENDING ☐ DENIED (ENCLOSE COPY)

19. WORKERS' COMPENSATION WEEKLY AMOUNT

$_____

DATE BENEFIT BEGAN (MO, DAY, YR)

RETIREMENT

20. IS EMPLOYEE COVERED BY EMPLOYER SPONSORED RETIREMENT PLAN? ☐ YES ☐ NO

21. DOES RETIREMENT PLAN CONTAIN A DISABILITY PROVISION? ☐ YES ☐ NO

22. IS EMPLOYEE, OR WILL THIS EMPLOYEE BE, ELIGIBLE FOR A DISABILITY OR RETIREMENT PENSION?

☐ YES IF "YES", MONTHLY AMOUNT $ _____ ☐ DISABILITY ☐ RETIREMENT ☐ OTHER _____
☐ NO DATE BENEFITS COMMENCE _____ (ENCLOSE COPY OF SUMMARY PLAN DESCRIPTION)

NOTE: IF ANY PORTION OF THIS PENSION BENEFIT IS ATTRIBUTABLE TO THE EMPLOYEE'S CONTRIBUTION, PLEASE PROVIDE DETAILS INCLUDING THE PERCENTAGE OF HIS/HER CONTRIBUTION TO THE TOTAL CONTRIBUTION.

MAIL THE FULLY COMPLETED FORM TO: THE GREAT-WEST LIFE ASSURANCE COMPANY
ATTN: CANUS COORDINATOR
GROUP POLICY SERVICES, 4 NORTH
60 OSBORNE STREET NORTH
WINNIPEG, MB R2C 1V3

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CERTIFICATION

23. EMPLOYER'S NAME		24. GREAT-WEST POLICY NUMBER **106269**
25. EMPLOYER'S TELEPHONE NUMBER	26. EMPLOYER'S FAX NUMBER	27. EMPLOYER'S EMAIL ADDRESS
28. ADDRESS		
29. EMPLOYER (TAXPAYER) I.D. NUMBER (EIN)	30. NAME OF PERSON COMPLETING THIS FORM (PLEASE TYPE OR PRINT)	
31. SIGNATURE OF AUTHORIZED INSURANCE REPRESENTATIVE	TITLE	DATE

SEPARATE AND SEND THIS FORM (WITH OTHER ENCLOSURES) TO THE ADDRESS SHOWN ON THE FRONT PAGE.

GIVE THE REMAINING FORMS TO THE CLAIMANT.