



Claimant's Statement Long Term Disability Application

Dear Claimant:

Complete and sign this Claimant Statement answering all questions in as much detail as possible. (Please assure that your full name, address and phone number is correct).

Sign and date the Authorization and Declaration section at the end of the Claimant Section. This will allow Unistar Special Risks Inc. to obtain additional information, if necessary, to make a decision on your claim. Please note that all information concerning your claim is kept confidential.

You are responsible for providing medical information to substantiate your disability claim, and this includes responsibility for providing medical reports. You are responsible for paying any costs incurred in obtaining this information. Unistar SRI will also be requesting medical information directly from your physician, if required.

Provide copies of any treatment notes and results from diagnostic tests that you may have from all physicians that have provided care to you since your last day of work.

If you do not provide the fully completed forms and all additional supporting documentation, your benefits could be delayed until all of the required information is received.

Once you have collected all of the forms, medical records and other relevant documentation, make a copy for your records and mail to the address below. To avoid delays in processing your claim, please fax and mail all documents three to four weeks before the end of your benefit period. **Confidential toll-free fax: 800.364.0754.**

For additional information, please contact us toll-free at 877.900.0250.

Suite 850 - 10655 Southport Rd. SW, Calgary, AS T2W 4Y1

Thank you.

Claimant Information

Claimant Name (first, middle initial, last): _____

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

Telephone Number (including area code): _____ Date of Birth (m/d/y): _____

Employer Name: _____

Employee Number: _____ Job Title: _____

First day of absence (m/d/y): _____

Please describe your reason for being absent from work: _____

Claimant's Name: _____ Claimant's Date of Birth (m/d/y): _____

Information about your Work

Last day worked prior to the injury or illness (m/d/y): _____

Prior to your last day worked, were you performing your usual job? Yes No If "No", please explain.

Since your work absence commenced, have you attempted to work? Yes No If "Yes", please give the dates and describe: _____

Information about your Injury or Illness

Date of the accident or date you first noticed symptoms of your illness (m/d/y): _____

Describe in detail how, when and where the accident occurred or describe the nature of your illness and its first symptoms: _____

Is your condition due to injury or illness related to your job or to a motor vehicle accident? Yes No If "Yes", please specify and explain. (Work Related Motor Vehicle Accident)

Have you filed or intend to file a Workers' Compensation claim? Yes No

If "Yes", please provide date. Date (m/d/y): _____

Have you ever had the same or a similar illness/injury? Yes No If "Yes", please give the dates and describe.

In comparison to your health on the first day of absence, how would you evaluate your present condition?

Worsened No change Improved Recovered

When do you expect to return to work? Date (m/d/y): _____

Claimant's Name: _____ Claimant's Date of Birth (m/d/y): _____

Date of the next appointment with your treating physician (m/d/y): _____

Date of the next appointment with a specialist, if applicable (m/d/y): _____

Please list other Physicians who have been/will be involved in assessing the medical conditions.

Name	Specialty	Date seen or to be seen	Telephone

Are you currently receive, or entitled to receive, benefits from any of the following sources?

Source of Income	Amount (per week or month)	Date Payments Began	Date Payments End
<i>QPP</i>			
<i>CPP / S.S.B.</i>			
<i>Workers' Compensation</i>			
<i>Other Group insurance</i>			
<i>Motor Vehicle Insurance</i>			
<i>Any Short Term Plan</i>			
<i>Employment Insurance</i>			
<i>Old Age Security</i>			
<i>Disability / Retirement Pension</i>			
<i>Severance</i>			
<i>Other</i>			

Claimant's Name: _____ Claimant's Date of Birth (m/d/y): _____

Claimant's Authorization and Declaration

I AUTHORIZE any physician, health practitioner, clinic or hospital or other medical organizations or any provincial motor vehicle board, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Unistar Special Risks Inc. having relevant information available as to my diagnosis, treatment and prognosis with regard to any physical or mental condition and/or treatment or tests completed on me, to provide to Unistar Special Risks Inc. and its duly authorized agents or representatives any and all such information to evaluate my application for benefits under the Long Term Disability Plan

I hereby authorize Unistar Special Risks Inc., or such designated agent or successor as may be appointed, and Echelon General Insurance Company and their respective authorized agents, including their legal representatives and investigators, to obtain, collect, receive, retain, examine, copy and disclose any personal information or personal health information, including consultation reports from or to any physician (including my treating physician) and/or any other medical practitioner, hospital, clinic, legal counsel, investigative agency.

The purpose for which this information is collected and for which it may be disclosed is i) to adjudicate and manage my claim, ii) facilitate rehabilitation and return to work, iii) in the context of litigation or legal claims or the assessment thereof, iv) management of the employment relationship, and v) for the policy holder's statistical purposes.

I ACKNOWLEDGE that Unistar Special Risks Inc. reserves the right to undertake an independent medical examination or consultation with my attending physician(s) for the purpose of determining my eligibility for payment of Long Term Disability benefits and provide a copy of any independent medical examination report to my treating physician(s).

I AGREE that any information provided to Unistar Special Risks Inc may be used by them for the assessment of my claim, and for any other purpose relating to the administration of my Long Term Disability benefits, including, but not limited to, use in assisting in my re-integration into the workplace. Only information related to work restrictions or fitness to work will be released to my Employer.

I declare that the statements provided in this Claimant Statement are true and complete.

Signature of Claimant: _____ Date Signed: _____