gpm group benefits

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SHORT-TERM DISABILITY CLAIM
Employee Form

Group No. _____ **GPM User ID** _____

INSTRUCTIONS

1. **FILL IN THE FORM.** If the disability benefits paid under the plan are taxable, the social insurance number must be provided for the preparation of tax forms.
2. **ATTACH THE REQUIRED CLAIMS.** In order to proceed with your claim GPM must receive the **Employer's claim statement** and the **Physician's claim statement**. (Obtaining the information provided in support of the present application is at your expense.)
3. **SIGN THE FORM.**

PARTICIPANT STATEMENT

Participant's Family Name(s) _____ Participant's Given Name(s) _____ Date of Birth (d/m/yyyy) _____

Address (Civic No. and Street Name) _____ Apartment _____

City _____ Province _____ Postal Code _____

Phone No. _____ Participant's Email Address _____ Gender ☐ F ☐ M

Job Title _____ Social Insurance No. _____

About Your Illness or Injury

Last day of full time duties (d/m/yyyy) _____

Please describe your illness or injury and explain how it prevents you from working: _____

Please describe the symptoms preventing you from performing your duties at work: _____

Disability Due to an Accident

Is your disability due to an accident? ☐ No ☐ Yes » Please indicate: **DATE** (d/m/y) _____ **TIME** _____ **LOCATION** _____

Benefits and Other Sources of Income

Please indicate any amount of money that you are currently receiving or expect to receive from the following sources. This information may be considered during the review of your claim.

Source		Amount ($)	Frequency of payment
Any Other Disability Insurance	◯ Yes:		weekly
CNESST	◯ Yes:		weekly
Employment Insurance	◯ Yes:		weekly
S.A.A.Q.	◯ Yes:		weekly

Source		Amount ($)	Frequency of payment
Canada and/or Quebec Pension Plan	◯ Yes:		monthly
IVAC	◯ Yes:		weekly
Any other income	◯ Yes:		weekly

DECLARATION AND AUTHORIZATION

By submitting your claim, you confirm that the information provided is accurate, precise and true. Any false information may result in the rejection of your claim. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry. I authorize GPM to use my social insurance number. I authorize any person or entity that has relevant personal information about me, including my employer, health professionals, my doctor, medical institutions, insurers, and persons performing services on behalf of GPM to disclose the information necessary to the activities of pricing, management and payment of claims. I authorize GPM to convey to my long- term disability insurance company any information about my absence to ensure the transition of my application to my long-term disability plan. I agree that I am responsible to keep the original documents relating to my claim for short-term disability. I agree that a photocopy of this authorization is as valid as the original.

PARTICIPANT'S SIGNATURE _____ Date (d/m/yyyy) _____