SHORT TERM DISABILITY PLAN

Frequently Asked Questions (Q & A)

Glossary of Terms

STD Application Form

A GUIDE TO HELP LOCALS NAVIGATE THEIR WAY THROUGH THE STDP

CANADIAN UNION OF POSTAL WORKERS

APRIL 2013

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RSMC

Q: Can a member who was on the Short Term Disability Plan and completed their 30 weeks of leave before January 1st, 2013 and is still off work, receive Extended Disability Benefit?

A: If a member is denied Extended Disability Benefits because their STD expired before January 1st, Locals are encouraged to grieve this until we can resolve the issue nationally.

URBAN OPERATIONS

Q: When is the start of the fiscal year?

A: The fiscal year is January 1st to December 31st. This should not be confused with the "leave year" as defined in clause 36.13 as April 1st to March 31st.

Q: What happens with a part time employee acting in a full time position, if they take a personal day or is approved for the STD how many hours will they be paid for?

A: Personal days are based on "scheduled hours" and STD pay is based on "regular hours".

Q: In the last few weeks of the Short Term Disability Plan why can I only top-up my pay to 95%?

A: Employment Insurance Regulations only allow for a 95% top-up.

Q: What happens to my pay if CPC has not approved my claim for STD within 8 calendars days?

A: A member will be paid STD benefits until a decision is rendered.

Q: What does it mean when they ask about "other income" on the STD application form?

A: It refers to other employment income.

20.10

(h) An employee's short term disability benefits will be reduced by any income received by the employee from the following sources:

- *(i) earnings from other employment, unless the employee can prove that this employment predated the injury or illness; however, such other employment, must not prevent or delay the recovery of the employee as determined by the Disability Management Provider;*
- *(ii) benefits payable under any Workers' Compensation program, where such a reduction is permitted by law;*
- *(iii) benefits from no fault government insurance or automobile insurance, where such a reduction is permitted by law;*

Q: Are Temporary Employees in Groups 1 & 2 covered?

A: Only temporary Employees with acquired rights; 44.17, 44.35 (b) (LETTER (NEW 3).

Q: Are group 3 temporary employees covered?

A: Yes, 44.33.

Q: Does a member have to use their personal days while they are waiting for Worker's Compensation to approve their injury on duty claim?

A: No.

24.03 Injury-On-Duty Leave:

As of the date on which the Short Term Disability Program is implemented, an employee shall receive seventy percent (70%) of his or her regular pay when he or she is incapacitated and unable to report to work as scheduled as a result of an injury that is pending a decision of a Worker's Compensation Board.

Q: Are Temporary Employees in Groups 1 & 2 covered?

A: Only temporary Employees with acquired rights; 44.17, 44.35 (b) (LETTER (NEW 3).

Q: Are group 3 temporary employees covered?

A: Yes, 44.33.

Case Manager

A Case Manager is an employee who works for the Disability Management Provider and who will handle and review your claim for Short Term Disability.

Toll free: 1-855-554-3148
Fax: 1-877-562-9126

Postal address:
50 Burnhamthorpe Road West, Suite 316
Mississauga, ON
L5B 3C2

Disability Management Provider

The company contracted by Canada Post to assess claims and administer the Short Term Disability Program.

Injury

An injury is damage or harm caused to the structure or function of the body, which may be physical or chemical.

Medical Consultant

The Medical Consultant is also known as the Occupational Medical Consultant. This person is an employee who works for the Disability Management Provider and provides interpretation of medical information.

Operation Specialist

An Operation Specialist is also known as Senior Case Manager. This person is an employee who works for the Disability Management Provider and is at a higher level than the Case Manager. They will review your claim for Short Term Disability with the Case Manager and possibly their Medical Consultant.

Senior Case Manager

See Operation Specialist.

Team Leader

The person whom an employee directly reports to.

Top-up Credits

Former sick leave credits. See Section 3 in how to use them.

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) First day of absence (dd/mm/yyyy) Expected return to work	☐ Full-time ☐ Part-time ☐ Term employee greater than 6 months	Team leader's name 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)

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SECTION D	Income or benefit Information (please print)			
Income / Benefit information		Start date	End date	Amount (indicate per week or monthly)
Have you applied for or are you receiving any of the following	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.

Attending Physician's Statement

Short-Term Disability Claim

Please complete this form as soon as possible to expedite the processing of your patient's claim for disability benefits under the Canada Post Short-Term Disability Program. It should be completed and returned within 14 days from the onset of the disability to avoid interruptions of payment to the employee. The completed form should be mailed or faxed directly to:

GREAT-WEST/MORNEAU SHEPELL
50 BURNHAMTHORPE RD W SUITE 316
MISSISSAUGA ON L5B 3C2
Fax: 1-877-562-9126

This form is not to be used for workplace injuries/illnesses

SECTION A To be completed by patient (please print)

Employee Name (Last, first, Middle initial)		
Employee ID number	Email	
Home phone number	Alternate phone number	
Address (number, street, city, province, postal code)		
Date of Birth (dd/mm/yyyy)	Bargaining Agent (if applicable)	Date form provided to physician (dd/mm/yyyy)

I hereby authorize the release of information held in my file by the physician named below to Great-West/Morneau Shepell and its agents and service providers for the purpose of assessing my claim and administering the disability plan regarding this claim. This medical information includes, but is not limited to copies of consultation reports, clinical notes, test results and hospital records supporting this claim. **I understand that I am responsible for any costs related to the completion of this form.**

Employee's signature — Date (dd/mm/yyyy)

SECTION B To be completed by the attending physician (please print)

Diagnosis(es) or working diagnosis(es) If psychological, please provide DSM IV Axis 1 diagnosis and GAF score GAF score (if applicable)	Primary Diagnosis Secondary Diagnosis	If childbirth, expected or actual delivery date (dd/mm/yyyy)

Is the diagnosed disability the result of: ☐ a non-occupational illness? ☐ a non-occupational accident?

Has the patient had a similar or related condition? ☐ **No** ☐ **Yes** If yes, state when and describe condition

Is the condition considered to be chronic? ☐ **No** ☐ **Yes** If yes, what precipitated the absence from work?

Date of first visit (dd/mm/yyyy) Date of last visit (dd/mm/yyyy)	Date first unable to work due to present condition(s) (dd/mm/yyyy) Expected date of return to work (dd/mm/yyyy)
Admitted to hospital? ☐ **No** ☐ **Yes** Date admitted (dd/mm/yyyy)	Name of institution Hospital department/ward admitted to Date discharged (dd/mm/yyyy)

Treatment (current medication, types of drug(s), dosage and duration, physiotherapy, other)

SECTION C Physician's acknowledgement and authorization (please print)

I acknowledge that the information in this statement will be kept in a health file with Great-West/Morneau Shepell and may be accessed 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.

Address (number, street, city, province, postal code)	Telephone number Fax number
Signature	Date signed (dd/mm/yyyy)

NOTE TO PHYSICIAN: If the disability is anticipated to be resolved within two weeks of its onset, no further information is required. If not, please complete section D.

SECTION D	Additional information for absences known/expected to exceed two weeks (please print)

Describe the employee's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other________________

Patient's height:________________ Patient's weight ________________

Is complete recovery expected? ☐ **No** ☐ **Yes**, anticipated period of recovery ________________

Please describe any factors that may affect this patient's ability to return to work

Please attach copies of all relevant test results/investigations and consultation reports (if test results are not attached, it will be assumed that tests were not performed)
If a consultation report is not attached please indicate if your patient has or will be seen by a specialist for this condition

Name of specialist Specialty Date of Visit

Please list any complications and additional condition(s) impacting your patient's level of function or the expected recovery period

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Physical impairment

Does your patient have a physical impairment? ☐ **No** ☐ **Yes**

If yes, please complete this section

Based on your assessment please describe your patient's current abilities in the following areas

Lifting (max. weight/frequency)		Sitting (how long/frequency)	
Carrying (max. weight/distance)		Standing (how long/frequency)	
Pushing/Pulling (max. weight/frequency)		Walking (distance/frequency)	
Walking on uneven ground (distance/frequency)		Climbing (how long/frequency)	
Working at heights (distance/frequency)		Crawling (duration/frequency)	

Remarks

Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation? ☐ **No** ☐ **Yes**

If yes, please complete this section

Indicate if patient currently has cognitive/mental restrictions in the following areas

	None	Mild	Moderate	Severe
Concentration (e.g. attention, orientation)				
Analytical reasoning (e.g. judgment)				
Learning new material (e.g. memory)				
Comprehension				
Social interaction (e.g. mood)				
Ability to multi-task				

In your opinion, is your patient competent to manage his/her own affairs? ☐ **No** ☐ **Yes**

Remarks

Rehabilitation/Work re-entry

Has your patient expressed a desire to return to work? ☐ **No** ☐ **Yes**

Expected date of return to work to full duties (dd/mm/yyyy)

Please provide details about return-to-work plans for the patient

To your knowledge is the patient following the recommended treatment program? ☐ **No** ☐ **Yes**

Has your patient's professional licence certification, driver's or other licence been restricted, suspended or revoked? ☐ **No** ☐ **Yes**

Physician Signature Date signed (dd/mm/yyyy)