Application for Group Short Term Disability Benefits – Temporary Foreign Workers Program

The completed application is required before claim assessment can commence. **This form should be completed in its entirety and submitted to Cigna within 5 days of the onset of the disability.** Cigna's Privacy Guidelines and applicable law allow workers to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the worker.

Ensure all sections and both pages are completed as a lack of information will cause delays in claim assessment.

A medical certificate must be attached to this form. The worker should place the medical certificate in an envelope before it is attached or given to the employer to attach.

The employer must complete sections A, B, and C, and the Declaration. The authorization request on page 2 must be signed by the worker.

A. EMPLOYER IDENTIFICATION			
Name and Contact	Plan Number		
Address: Street & Number P.O. Box	City	Province	Postal code

B. WORKER IDENTIFICATION				
Name: First	Initial	Last	Employee I.D. Number	Date of Birth

C. EMPLOYMENT INFORMATION		
Date of arrival in Canada (MM/DD/YYYY)	Date last worked (MM/DD/YYYY)	
Reason for absence ☐ Non-work related sickness or accident	☐ Work related sickness or accident	
Has worker returned to work? ☐Yes _____ (MM/DD/YY) ☐No	If no, is a return to work date known? ☐Yes _____ (MM/DD/YY) ☐No	Expected date of departure from Canada? _____ (MM/DD/YY)
Please provide the average weekly wages for the previous four weeks. If the worker has less than four weeks' wages, please provide the average weekly wage for the entire period prior to the last day worked: $_____		
Please attach copies of the worker's payroll records for this period.		

ADDITIONAL INFORMATION
Please provide any additional information that you believe should be considered in assessing this worker's claim

DECLARATION	
I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.	
Authorized Signature:	**Date:**
Name (Please print):	**Title:**
Phone:	**Fax:**

By signing this form, you are authorizing Cigna to share your personal information for the purpose of assessing your claim. Use of your personal information is subject to Cigna's Privacy Guidelines and applicable law.

PROTECTING YOUR PERSONAL INFORMATION

At Cigna, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Cigna, or the offices of an organization authorized by Cigna. This information about you may include medical and psychiatric information. Cigna may use service providers located within or outside Canada. We limit access to personal information in your file to Cigna Staff or persons authorized by Cigna who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Cigna and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), please visit Cigna's website at www.cigna.com

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Cigna, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Cigna or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Cigna and administering the group benefits plan. This may include performing independent assessments;
- Cigna to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Cigna and to administer the group benefits plan. I acknowledge that my consent enables Cigna to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements from the basis for any benefit approved.

Signature: _____ Date: _____