Short-Term Disability Program

Your 6-page Application Kit

Overview

The Short-Term Disability Program (STDP) ensures consistent treatment for all employees who are absent from work due to an illness or a non work-related accident. It provides coverage to all eligible employees regardless of their medical history or how long they have been with Canada Post. It exists to:

- ensure employees receive the right support at the right time;
- encourage a healthy, timely and safe return to work;
- assess early accommodation potential; and
- reduce the financial impact of a workplace absence.

Canada Post is committed to finding safe and suitable work for your return, including modified duties where applicable.

Eligibility

Those who meet eligibility requirements will receive STDP benefits if deemed: ill for more than seven calendar days; had a non work-related accident; or hospitalized. If unsure of whether you are eligible, ask your team leader or refer to STDP-Central on Intrapost.

Forms

This kit contains two forms that must be completed and returned to Morneau Shepell: the *Attending Physician's Statement* and the *Employee Statement*. You are responsible for any costs related to the completion of the *Attending Physician's Statement*. Send by fax or mail to the address indicated on the forms. If the forms are not received within **seven calendar days**, there may be a delay in processing the claim, and your **pay may be interrupted.** Any period of time paid as pending that is not supported, will be **recovered.**

Assessment of claims

To receive benefits under the STDP, your claim must be supported by Morneau Shepell. Information provided by the treating physician must demonstrate that you are unable to work as a result of your illness or accident.*

To continue to receive benefits, you must be under the care of a physician or other regulated health-care professional and following an appropriate treatment program.

Employee responsibilities

Throughout your claim, you must continue to provide satisfactory proof of your continued total disability, actively participate in the disability-management program, keep your team leader and case manager informed, and accept appropriate accommodations.

* **Privacy**: Canada Post's privacy policies dictate that our disability management providers are required to protect the privacy of our employee's personal information, to treat all medical information collected as confidential and to protect such information from improper and unauthorized use and disclosure.

22-054-300 (15-07)

Short-Term Disability Program

Application process for Canada Post employees

- Unable to work because of illness lasting **more than 7 calendar days?**
- Recovering from a non work-related accident?
- Are you hospitalized?

5 things you need to do under the STDP application process

1

☐ **REPORT** to your team leader immediately.

2

☐ **CALL** Morneau Shepell **24 hours after** informing your team leader. The number is **1-855-554-3148**. (Morneau Shepell is open Monday to Friday, 24 hrs)

☐ **BOOK** an initial telephone assessment with a case manager at Morneau Shepell.

3

☐ **OBTAIN** an *STDP Application Kit* on Intrapost (ESS, STDP-Central), from your team leader or on canadapost.ca (I'm an Employee). The kit contains the two required forms you will need: *Attending Physician Statement* and *Employee Statement*.

4

☐ **VISIT** your physician and **ensure the *Attending Physician Statement* form is completed and submitted** to Morneau Shepell within 7 calendar days.

5

☐ **SUBMIT** to Morneau Shepell the completed *Employee Statement* form within 7 calendar days.

Remember, it is critical to follow the treatment plan prescribed and keep your case manager and team leader informed.

22-054-300 (15-07)

CANADA POST / POSTES CANADA

Attending Physician's Statement

Short-Term Disability Claim

Please complete this form as soon as possible with all relevant and pertinent information 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 7 calendar 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:

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 or health care professional (please print)

Diagnosis(es) or working diagnosis(es): If psychological, please provide DSM V Axis 1 diagnosis. 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 for current disability (dd/mm/yyyy): Date of last visit for current disability (dd/mm/yyyy):	Date first unable to work due to current disability (dd/mm/yyyy): Expected date of return to work (dd/mm/yyyy):
Admitted to hospital (inpatient or outpatient)? ☐ **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 / Healthcare Professional'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 / HEALTHCARE PROFESSIONAL: 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 patient's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living.

Frequency of visits: ☐ Weekly ☐ Monthly ☐

Patient's height: _____ Patient's weight: _____

Is complete recovery expected? ☐ **No** ☐ **Yes,** Expected Recovery Date : _____

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: _____

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.

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)		Standing (duration/frequency)	
Carrying (max. weight/distance)		Walking (distance/frequency)	
Pushing/Pulling (max. weight/frequency)		Climbing (duration/frequency)	
Walking on uneven ground (distance/frequency)		Crawling (duration/frequency)	
Working at heights (distance/frequency)		Keying/Typing (duration/frequency)	
Sitting (duration/frequency)		Mousing (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 any concerns related to return to work? ☐ **No** ☐ **Yes,** Please describe:

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 / Healthcare Professional Signature :	Title/Profession:	Date signed (dd/mm/yyyy):

Employee Statement
Short-Term Disability 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 7 calendar days of the start of the disability to avoid interruptions in payments.** The completed form should be mailed or faxed directly to:

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:	Alternate 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):	☐ Full-time	Team leader's name:
First day of absence (dd/mm/yyyy):	☐ Part-time	
Expected return to work:	☐ Term employee greater than 6 months	Telephone number:
Job title:	Describe your job duties:	
Do you: ☐ Work alone ☐ Interaction with public ☐ Supervise others ☐ 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 or admitted to a clinic (inpatient or outpatient)? ☐ **No** ☐ **Yes**

Name of Institution:	Name of ward/unit:
Date admitted (dd/mm/yyyy):	Date discharged (dd/mm/yyyy):

SECTION D Income or benefit Information (please print)

Income / Benefit information Have you applied for or are you receiving any of the following:		Start date	End date	Amount (indicate per week or monthly)
	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 (where employment started after last day worked at CPC)			
	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/Health care professional(s)

Name of primary attending physician/health care professional:

Physician's/health care professional 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 attending physician/health care professional, Great-West/Morneau Shepell and its agents and service providers and any person or organization who has relevant personal information about me, including health care 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 recover excess amounts paid.