Short-Term Disability Benefits Claim Form

(due to personal non-occupational disability)

This form is required for absences due to a personal non-occupational disability that are in excess of five (5) working days. It must be submitted to the Disability Management Section as soon as possible, preferably by the seventh (7th) day of absence. Delaying your submission may result in a disruption to your pay.

All questions on page 2 and 3 must be answered in full by a licensed physician and legible. Any incomplete or illegible forms could result in delay of benefits.

Employee Name:		Employee ID/PR#:	Dept. #:
Position:	Address:		Home Phone:
City/Town:	Prov:	Postal Code:	Alt. Phone:
Supervisor Name:			Supervisor Phone:
First Day/Shift Absent:			

If the medical information you provide is deemed incomplete by the City of Edmonton, a Disability Management Consultant will contact you to obtain additional information.

In the event further information or clarification is required after the form is submitted, the Disability Management Consultant will make reasonable attempts to contact you by telephone and/or email to discuss the information required, which may include additional documentation or a request for consent to contact your physician.

In accordance with the Collective Agreement, all City of Edmonton employees wishing to leave the greater Edmonton area or engage in any other employment for gain while absent from work due to illness/injury must obtain prior approval from their Disability Management Consultant. Without prior approval, you may not be entitled to receive benefits. No reasonable request will be denied

Employee Signature: _____ Date: _____

Employees must pay the physician directly and then will be reimbursed up to $40.00 for costs associated with the completion of this form. Incomplete or illegible medical forms may not be covered.

Submit completed form and receipts to:
Disability Management Services, 11th Floor, Century Place,
9803 102A Ave NW Edmonton, AB T5J 3A3
Fax: 780-496-9227
Email: disabilitymanagement@edmonton.ca

Short-Term Disability Benefits Claim Form

(due to personal non-occupational disability)

Must be completed by the Physician. All questions must be legible and answered in full . Failure to meet these requirements may result in delay in payment of benefits. Please call 780-496-8835 if there are questions regarding form completion. When completing this form, disclose only information necessary to meet the purpose of the form.

Patient Name:	**Date of first visit:**
Nature of illness/injury (Typically, it is not necessary to provide a diagnosis or treatment information.)*:*	
Is there a treatment plan in place? **Is your patient compliant with the treatment plan?** (Note: the City of Edmonton has a variety of programs/services in place that may help in your patient's recovery (for example: Employee Family Assistance Program, expedite diagnostics, etc). Should you wish for the City to assist, please provide the service(s) that may be required.	
Prognosis : (Duration of Disability) When do you anticipate that your patient will be able to return to work?	Modified duties (date):
	Regular Duties (date):

Functional Ability

Please complete this section if your patient is capable of performing modified duties. Capable of modified duties? Yes ☐ No ☐

If Yes, the City of Edmonton has a comprehensive and supportive modified work program aimed to accommodate physical and mental health challenges our employees may be experiencing. Information related to current abilities will assist us in proactively supporting the employee's return to work plan.

Task	**Restricted**		**< 10 lbs**	**10-20**	**30-49**	**50-100**	**Frequently**	**Occasionally**	**Comments**
Lifting	Yes ☐	No ☐							
Carrying	Yes ☐	No ☐							
Pushing	Yes ☐	No ☐							
Pulling	Yes ☐	No ☐							

Task	**Restricted**		**Please identify ability in distance, duration, the need for self pacing and micro breaks (if required)**
Walking	Yes ☐	No ☐	
Standing	Yes ☐	No ☐	
Sitting	Yes ☐	No ☐	

If you answered YES to any of the following questions please provide additional information in the space below

Environmental Sensitivities (Heat, Cold, Fumes, Odors, etc)	Yes ☐	No ☐	Driving Restrictions (Class 5, other)	Yes ☐	No ☐	Medical aids (splint, brace)	Yes ☐	No ☐
Heights/Depths/ Confined Spaces	Yes ☐	No ☐	Effects of Medication	Yes ☐	No ☐	Fine Dexterity	Yes ☐	No ☐
Repetitive use of Hands or Feet	Yes ☐	No ☐	Hearing, Vision or Speech	Yes ☐	No ☐	Other (Specify in comments)	Yes ☐	No ☐

Mental/Other

Thinking/Reasoning	Yes ☐	No ☐	Critical decision-making	Yes ☐	No ☐	Shift work/Duration of shift/ Overtime	Yes ☐	No ☐
Concentration	Yes ☐	No ☐	Ability to Interact with Others	Yes ☐	No ☐	Operating Vehicle/Equipment	Yes ☐	No ☐
Memory	Yes ☐	No ☐	Alertness	Yes ☐	No ☐	Other (Specify in comments)	Yes ☐	No ☐

Next date of follow up appointment: _____

Comments/Additional Information:

_____

_____

Physician Signature: _____ Date: _____

Physician Name: Phone: Fax:

Is this work related? Yes ☐ No ☐ If yes, the City will report to WCB in accordance with the Worker's Compensation Act Section 33.

Bill patient directly for the completion of this form. Max. employee reimbursement is $40.00

All personal information is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act. It will be used in the administration of Human Resources policies and programs, including eligibility for disability benefits and development of return to work plans. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact Disability Management Services, 11th Floor Century, 9803 102A Ave, Edmonton, AB, T5K 3A3. (780) 496-8835.

Consent to Release Information

This form is being provided to you as a courtesy should Disability Management ask you for consent to contact your treatment provider) in order to obtain additional information that may be required to process your claim. Completion of this form is not required at this time - it is your choice as to whether to submit it at this time. The purpose of providing it to you at this time is to ensure there are no delays in getting a signed form from you if we later need it.

I **_____** **do hereby authorize** **__ _____**
(Employee's Name) **(Name of Physician or Treatment Provider)**

-and-
Disability Management Services
The City of Edmonton

To exchange medical information required for the management and adjudication of my claim for disability benefits, and any information related to my absence to assist with return to work planning efforts.

Service Provider	Yes	No	Service Provider	Yes	No
Physical Therapy provider **[ ]**			**Union Representative** **[ ]**		
Chiropractor **[ ]**			**Third Party Insurance** **[ ]**		
Specialist **[ ]**			**Independent Medical Service Providers** **[ ]**		

Consent to Release Information:

If the medical information I have provided is deemed incomplete by the City of Edmonton, I understand that a Disability Management Consultant will contact me by telephone or by email to discuss what additional information or clarification may be required in order to review my claim further. I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting or refusing to consent. I understand that prior to contacting my treatment provider, the Consultant will make reasonable attempts to contact me by telephone at _____ or by email at _____to advise me of their intention to contact my treatment provider in writing. My consent to permit access to additional medical information provided by my treatment provider, as it relates to my current absence, is effective the date set out below and will only be valid for 180 days. I understand that I may revoke this consent in writing at any time. I agree that a photocopy or facsimile of this authorization is as valid as the original.

Employee's Name		**Employee's Signature**	
Date Signed			

All personal information is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act. It will be used in the administration of Human Resources policies and programs, including eligibility for disability benefits and development of return to work plans. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact Disability Management Services, 11th Floor Century, 9803 102A Ave, Edmonton, AB, T5K 3A3. (780) 496-8835.