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 weekly 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 Canada Post)			

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's speciality (if applicable):	Date of first treatment 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 administering 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.