SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

EMPLOYEE'S GUIDE: HOW TO SUBMIT A DISABILITY CLAIM

PLEASE NOTE

If you have been absent from your work for any period of time and you have Disability benefits under Saskatchewan Blue Cross, claim forms are available through your Employer or can be accessed on our website at **www.sk.bluecross.ca/forms**.

WHAT FORMS ARE REQUIRED?

The following forms can be found on our website at **www.sk.bluecross.ca/forms** under the Disability Claims category:

- Employee's Statement: Application for Benefits
- Employee: Education and Work History
- Physician's Statement: General or Psychiatric (choose the applicable form for your condition)
- Direct Deposit Authorization - Member form (this can be found under the 'Group Benefits' category)
- Photo or scan of your Driver's Licence, Passport or similar valid proof of age

Please note: Your Employer will complete the Employer Statement and Job Description and submit them to Saskatchewan Blue Cross.

WHAT DO I NEED TO DO TO SUBMIT A DISABILITY CLAIM?

We want to make sure your claim is processed as accurately and quickly as possible. Please ensure that you follow the steps below to avoid any delays in potential payments.

STEP ONE

Complete the Employee Statement (including proof of age), Authorization and Education and Work History. Ensure that you answer all of the questions on these forms. You may attach any other additional information that you feel is necessary to your claim on a separate sheet.

Please also complete the Direct Deposit Authorization and send your completed application forms to our office at:

Saskatchewan Blue Cross
516 2nd Avenue North
PO Box 4030
Saskatoon, SK S7K 2C5

Alternatively, you may fax your documents to 306.667.5495 or submit them electronically through your secure Saskatchewan Blue Cross Member Portal. Please do not email completed forms, as they contain sensitive information.

STEP TWO

Complete and sign Part 1 of the Attending Physician's Statement and ask your doctor to complete the form that is most appropriate for your condition. If you have undergone any tests or seen any specialists, please ensure that your physician includes copies of the test results and specialist's reports. Requests for medical and health information exclude genetic test results. If you have any questions regarding which physician should be completing these forms, please do not hesitate to contact us at 1.800.667.6853.

Note: Please be advised that it is your responsibility to follow up with your doctor(s) to ensure the medical information is submitted, and for any costs for the completion of the Attending Physician's Statement.

STEP THREE

Your Employer will complete the Employer's Statement and Job Description and will forward them directly to Saskatchewan Blue Cross.

We strongly recommend all information be submitted as soon as possible to avoid any delays in our assessment.

WHAT HAPPENS NEXT?

A Disability Case Manager will review the claim within 5 – 10 business days from the date that all required information has been received. They will review the medical information provided, the functional limitations, abilities and the demands of your job related to your condition.

The Disability Case Manager will also conduct a telephone interview with you to better understand your functional capabilities and limitations, as well as to clarify any questions they may have in regard to your occupation, work environment and your ability to perform duties around your home and while at work.

Once all pertinent information is gathered and assessed, a decision will be made on your claim. If further information is required to assess your claim, we will notify you in writing.

WHAT IF MY CLAIM IS PENDED — WHAT HAPPENS NEXT?

If Saskatchewan Blue Cross determined that additional information is required to complete our assessment of your claim, we will advise you verbally and in writing and will notify your Employer in writing. Please ensure you follow up promptly with any additional information requested.

GUIDE CONTINUES ON NEXT PAGE.

IF MY CLAIM IS APPROVED, WHAT HAPPENS NEXT?

We will call you and contact your Employer to advise of our decision to approve your claim. We will explain to you the effective date of the benefit, the amount you will be receiving and the definitions in the contract as they pertain to your claim.

We will then send an approval letter that confirms our decision and outlines the requirements for you to continue to qualify for Disability.

The most effective disability management occurs when there is a collaborative team approach with the Employer, Employee, medical community and the Insurer. Some of which include:

- Ongoing Employee and Employer contact
- Periodic medical updates (including writing directly to your treating physician or forwarding an Attending Physician's Statement to you to be completed by your physician)
- Once appropriate, helping to facilitate a gradual return to work program

RETURN TO WORK PLANNING

If it is anticipated that you will be able to return to gainful employment as defined by the definition of Disability, as stated in your Contract, we will assist in coordinating a personal return to work program. This unique program may include a referral to a Rehabilitation Consultant.

If your medical condition improves and you can return to some degree of work, either full-time or part-time, it is important to notify us immediately.

IF MY CLAIM IS DECLINED, WHAT HAPPENS NEXT?

If the results of our assessment indicate you are not eligible for benefits as you are not disabled from performing the duties of your job as defined in your Contract, your claim will be declined. We will call you and contact your Employer with the decision of your claim. Please note that medical information is confidential and cannot be discussed with your Employer.

We will send you a letter outlining the reasons for our decline and how to appeal our decision should you disagree. It may be helpful for you to review the decline letter with your physician when deciding what medical information would be most appropriate for the appeal. New medical information is required to appeal the decline decision and must be received in our office within 90 days of the date of the decline letter.

Please note: You are responsible for the cost of providing additional medical information for an appeal.