

A Step-by-step Guide to the Disability Claim Process

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It is common in a workplace that some employees will become unable to work due to illness or injury. Employers understand this and have programs in place to assist employees, both medically and financially, until such time as they are able to return to work.

If you have questions about your Disability Insurance (DI) Plan you may contact your departmental Human Resources and/or your bargaining agent representative. You may also consult the following website:

http://www.tbs-sct.gc.ca/hr-rh/bp-rasp/benefits_avantages/dip-rai/dip-rai-eng.asp

What are DI Benefits

The Federal Government DI Plan is designed to replace a portion of lost income if you become “totally disabled” for a prolonged period.

If you are totally disabled and feel you qualify for benefits under the DI Plan, you must complete a claim form. You must also provide medical information that Sun Life Assurance Company of Canada (Sun Life) requires in order to assess your claim.

The process is not adversarial but you are responsible to provide information to verify your disability. This will be used to consider your claim, rehabilitation, and recovery needs. All parties involved strive for a quick and safe return to work.

What does Totally Disabled mean?

First 24 months

“Totally disabled” means that you have an illness or injury that prevents you from performing each and every duty of your regular occupation.

After 24 months

“Totally disabled” means that your illness or injury prevents you from performing the duties of a “commensurate occupation”. A “commensurate occupation” is any occupation for which you are either qualified, or could become qualified by education, training or experience, and that would earn you at least 66 2/3% of your pre-disability salary.

What happens when Sun Life receives my claim?

Sun Life's Abilities Case Manager (ACM) considers the following factors when assessing your claim:

- your medical information;
- your ability to function and carry on daily activities;
- your job demands;
- your work environment; and
- how your condition affects your ability to perform your occupation.

The ACM will contact you by telephone for more information. At that time you will be able to ask questions about your claim. The ACM may also need to contact your doctor and/or your employer to obtain additional information. Once all necessary information is received, your claim is usually assessed within 10 business days. The ACM will notify you and your department in writing of the decision.

NOTE: You will need to provide Sun Life with information supporting your medical condition without delay. You are responsible for any expenses related to obtaining this information in support of your claim from your doctor(s).

How are my DI Benefits calculated?

Benefits:

- are equal to 70% of your insured monthly salary;
- are taxable;
- are indexed to a maximum of 3% per year to reflect cost of living changes;
- may be offset by other income.

How and when are payments made once the claim is approved?

Benefits are payable after the elimination period (after 13 weeks of total disability) or when your paid sick leave ends, whichever is later.

Benefits are then paid on a monthly basis. You will receive your first benefit payment at the end of the month in which your elimination period ends.

NOTE: It is your responsibility to advise Sun Life if you receive benefits or income from other sources, including any retroactive adjustment or award (e.g. PSSA pension, CPP/QPP disability benefits). A retroactive payment

could result in an overpayment of Sun Life benefits. If this occurs you are responsible for reimbursing Sun Life the full amount you have been overpaid.

What is Vocational Rehabilitation?

Sun Life and the Federal Government believe that work is healthy and important to recovery. Vocational rehabilitation focuses on what is needed to prepare for your early and safe return to work, taking into account your abilities and restrictions. Your return-to-work plan could include, for example, graduated return to work and/or a return to modified or part-time duties to help you adjust. Should your return to work require specific vocational expertise, a Health Management Consultant (HMC) may become involved to assist with coordinating your return to the workplace. In partnership with the ACM, the HMC would work with you, your employer, and your health care providers to create your return to work plan. The earlier a plan is incorporated into your overall recovery and treatment program, the easier your successful return to work will be. The HMC may access a variety of career and vocational rehabilitation services to provide you with a complete return to work program.

What if my claim is denied?

If your claim is denied, you will be advised in writing. You will be provided with details of what information is needed to appeal the decision. There are two opportunities within Sun Life to appeal the decision on your claim.

1st Appeal – The ACM will review the new information that you provide. If it is not sufficient to change the decision, your claim will be forwarded in its entirety to the next level of management. They will review the ACM's findings, and if the decision remains unchanged, will issue a letter that will explain the decision and indicate the information needed to appeal to the 2nd level.

2nd Appeal – The Sun Life Management Unit will review the new information that you provide. If it is not sufficient to change the decision, your claim will be forwarded in its entirety to the next level of management. They will review the Sun Life Management Unit's findings, and if the decision remains unchanged, will issue a letter that will explain the final decision. If your claim remains closed, this completes Sun Life's internal appeal process.

Disability Insurance Plan Board of Management

Once the two levels of appeal within Sun Life have been exhausted, you may request an independent review by the DI Plan Board of Management. This Board, which is comprised of both management and federal public service union representatives, reports to the National Joint Council. The Board reviews each case and endeavours to recommend a course of action to the insurer or the employee which may facilitate a resolution to the case. Such recommendations are not binding, but the Board has been able to bring many cases to a satisfactory resolution.

Requests for independent review should be sent to:

The Secretary DI Plan Board of Management

National Joint Council
C.D. Howe Building, West Tower
7th Floor, 240 Sparks Street
P.O. Box 1525, Station B
Ottawa ON K1P 5V2.

Sun Life Ombudsman's Office

If at any time during the claim management process you feel you have been dealt with unfairly or you have a complaint about a service provided by Sun Life, you should contact the Sun Life Ombudsman's Office. They cannot evaluate medical evidence or make decisions. The Ombudsman's role is to thoroughly and objectively investigate complaints and act as a mediator to explore possibilities that may lead to a resolution.

Ombudsman's Office, Sun Life

225 King Street W., 7th Floor
Toronto, ON M5V 3C5
Phone: 416-408-8954
Toll-free: 1-800-786-5433
FAX: 416-595-1431
E-mail: ombudsman@sunlife.com

To contact Sun Life

Toll-free number: 1-800-361-5875

Toll-free fax number: 1-866-639-7849

STEP 1
**CLAIM IS RECEIVED
BY SUN LIFE**

Sun Life receives the following fully completed forms:

- a) Employee Statement (TBS/SCT 330-302)
- b) Employer's Statement (TBS/SCT 330-303)
- c) Employee's Medical Information and Attending Physician's Statement (TBS/SCT 330-304)

Within five business days of receiving your claim forms above, Sun Life will acknowledge receipt to you and begin evaluating your claim.

INCOMPLETE INFORMATION

If a decision cannot be made on your claim due to lack of information, Sun Life will notify you by letter and send a copy to your department.

STEP 2
CLAIM IS REVIEWED

Within ten business days of your claim forms, Sun Life will assess your claim to determine if you are eligible for disability benefits.

- Claim is approved, GO TO STEP 3.
- Claim is denied, GO TO STEP 2A.

STEP 2A
CLAIM IS DENIED

You will be advised in writing. You will be provided with details of what information is needed to appeal the decision.

See STEP 2B.

STEP 3
CLAIM IS APPROVED

Sun Life will send you a letter providing all calculations, the date your benefits will start and how much you will receive.

See "How and when are payments made once the claim is approved" on page 37 above.

STEP 4
VOCATIONAL REHABILITATION

Vocational rehabilitation focuses on what is needed to prepare for your early and safe return to work, taking into account your abilities and restrictions.

See "What is Vocational Rehabilitation" on page 38 above.

STEP 2B
THE APPEAL PROCESS

1st Appeal - Sun Life will review the new information that you provide and if the decision remains unchanged, will issue a letter that will explain the decision and indicate the information needed to appeal again.

2nd Appeal - Sun Life will review the new information that you provide and if the decision remains unchanged, will issue a letter that will explain the final decision. If your claim remains closed, this completes Sun Life's internal appeal process.

See "What if my claim is denied?" on page 38 above.

- Claim is approved, GO TO STEP 3.
- Claim is declined. You may request independent review by DI BOM

See "The Appeal Process" on pages 37-38 above.

Sun Life Assurance Company of Canada (the Insurer) and The Treasury Board of Canada are pleased to provide this outline of the claims process for your Disability Insurance Plan.

FOR MORE INFORMATION

Call our toll-free number: **1-800-361-5875**

or FAX our toll-free number: **1-866-639-7849**

