canada life™

CANADA POST: HIGH RISK LEAVE OF ABSENCE

INSTRUCTIONS

1. Part 1 and 3 to be completed by the employee
2. Part 2 to be completed by the physician
3. Send completed form to: Email: HRL@canadalife.com / Fax: 1-844-569-3136 / Mail: PO Box 896, Stn Main, Winnipeg, MB, R3C 2T2

Part 1: Employee Identification

First Name: ______ Middle Initial: ______ Last Name: ______

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of Birth: ______ Canada Post Employee ID Number: ______

Home Address: ______

City / Town: ______ Province / Territory: ______ Postal Code: ______

Home Phone: ______ ☐ Confidential

Cell Phone: ______ ☐ Confidential

Check the Confidential box if you authorize us to leave a message containing personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Email Address: ______

Enter your email address if you would like Canada Life to communicate with you by secure email about your high risk leave of absence.

Part 2: Attending Physician's Statement (to be completed by physician or treatment provider)

ANY FEE CHARGED FOR PROVIDING THIS INFORMATION IS THE PATIENT'S RESPONSIBILITY

1. As of the date you complete this form, has your patient been diagnosed with an underlying medical condition that the Public Health Agency of Canada considers at risk of developing severe complications from COVID-19? ☐ Yes ☐ No

2. Do you recommend that your patient self-isolate for medical reasons? ☐ Yes ☐ No

   If yes, what period of time are you recommending that they self-isolate and why? Start ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy).

   Comments:

   ______

   ______

   If no, is there any reason the employee cannot continue working at their job at Canada Post?

   Comments:

   ______

   ______

The information in this statement will be kept in a life, health or high risk leave of absence file with the insurer or plan administrator and might be accessible 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.

Name of Physician (please print): ______ Specialty: ______

Email Address: ______ Telephone: ______ Fax: ______

Address (number, street, city, province and postal code): ______

Physician's Signature: ______ Date: ______

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.

Part 3: Consent and Authorization for High Risk Leave

This Consent and Authorization applies to your application for High Risk Leave provided by Canada Post. Canada Post's High Risk Leave application process is administered by The Canada Life Assurance Company (Canada Life). You must sign, date and submit this Consent and Authorization in order for your High Risk Leave to be administered.

Medical information you give to our disability-management providers is being collected for the purposes of administering your High Risk Leave, and will be kept strictly confidential and protected from unauthorized use, retention, and disclosure.

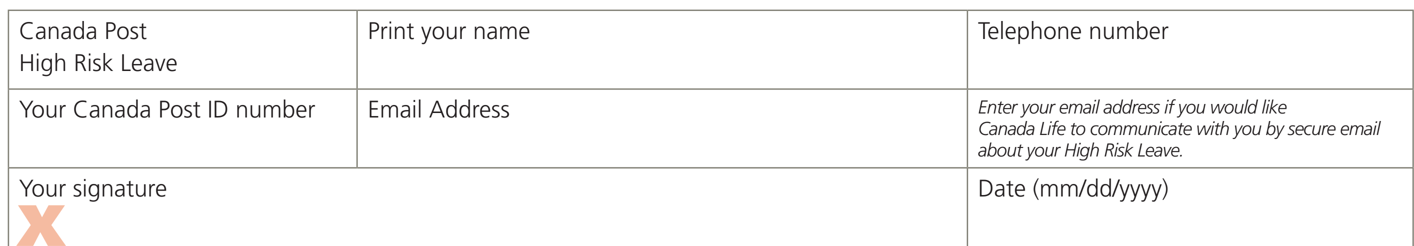
I certify that all statements that I've made and information provided related to my High Risk Leave are true and complete, to the best of my knowledge. I understand that my High Risk Leave may be terminated as a result of my providing false or misleading information or omitting relevant information.

I authorize my attending physician / health care professional, Canada Life and its agents and service providers, and any person or organization who has relevant personal information about me, including other health care professionals and organizations, to exchange information about me (including my personal medical information) in accordance with privacy guidelines for the purpose of determining my eligibility for, and administering my, High Risk Leave.

I authorize Canada Life in accordance with privacy guidelines, to use and exchange any personal information about me (including medical information) with Canada Post for the purposes of determining my eligibility for High Risk Leave, managing my return to work and administering the High Risk Leave program.

I agree that a photocopy of this authorization shall be as valid as the original. My authorization is valid for the duration of my High Risk Leave or until I cancel it in writing; however, I understand that withdrawing my consent may result in Canada Post's denial or termination of my High Risk Leave.

For a copy of our Privacy Guidelines see **canadalife.com** or you can write to Canada Life's Chief Compliance Officer



Canada Post High Risk Leave	Print your name	Telephone number
Your Canada Post ID number	Email Address	*Enter your email address if you would like Canada Life to communicate with you by secure email about your High Risk Leave.*
Your signature X		Date (mm/dd/yyyy)

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.