# Employee Statement - GHC - Return to Health®

*Disability Form*

Please complete and return this form promptly for the processing of your request for disability benefits. Cowan Benefits Ltd. is committed to keeping your personal information confidential.

**Cowan Benefits Ltd., Return to Health®** **Email:** rthclient.service@cowangroup.ca **Fax:** 1-866-508-4111

## Section A: Employee Information

| First Name: | Last Name: | Date of birth: |
|---|---|---|
| Address: | | |
| Home Phone Number: | Personal Email: | |
| Preferred method of communication: ☐ Phone ☐ Email | | |
| Position/Job Title: | | |
| Employer Name: | | |
| Employee ID Number: | | |

## Section B: Claim Information

| Date symptoms first appeared: MM\|DD\|YYYY | Last day worked? MM\|DD\|YYYY |
|---|---|
| First doctor visit for current condition: MM\|DD\|YYYY | |
| Date of most recent medical visit: MM\|DD\|YYYY | Date of next visit: MM\|DD\|YYYY |

Have you experienced a similar condition before? ☐ Yes ☐ No If yes, when? MM|DD|YYYY

Do you have any symptoms that are preventing you from performing your essential job tasks? Yes ☐ No ☐

Are you currently participating in treatment for your condition? Yes No

Date started: MM|DD|YYYY

Do you have any other health problems that may prolong your recovery? ☐ Yes ☐ No

Please describe how your injury or illness *prevents* you from performing your essential job tasks?



Revised_February 2025

Cowan

# Employee Statement – Return to Health®

*Disability Form*

**Employee Name: (please PRINT)**_____ **Date of Birth:**_____

**Employer Name:** _____ **Employee ID #:** _____

## Section C: Employee Consent

I CERTIFY the statements in this form are true and complete.

I AUTHORIZE AND DIRECT the physician, health practitioner, clinic or hospital, receiving this form, by whom I have been attended in connection with my disabling physical and/or mental condition, to provide any medical information available, relevant to this form by written communication with respect only to my current disabling physical and/or mental condition (the "Medical Information") to Cowan Benefits Ltd. ("Cowan") and associated medical professionals. I hereby also permit and authorize my employer to receive my claim status, including functional restrictions, limitations and/or modifications necessary for my return to work.

I ACKNOWLEDGE AND AGREE that Cowan Benefits Ltd. may investigate my claim. I understand that Cowan Benefits Ltd., its agents, administration and service providers may investigate my claim. Cowan Benefits Ltd. will advise me of their intention to contact health care providers, institutions, insurers, or others in the course of their investigation and will seek my further consent for each such inquiry.

I AGREE that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

I UNDERSTAND AND AGREE that Cowan Benefits Ltd. administers your employer's Short Term Disability plan on their behalf. Your employer funds all the costs associated with your Short-Term Disability benefit plan including Short-Term Disability benefit payments.

| **Employee Full Name (please print)** | |
|---|---|
| **Employee Signature**<br>✕ | **Date** (MM/DD/YYYY) |

The completed form may be faxed, e-mailed or mailed to the following address:


**Cowan Benefits Ltd., Return to Health®**

225 King George Road, Brantford ON, N3R 7N7

**Email:** rthclient.service@cowangroup.ca

**Fax:** 1-866-508-4111

**Phone:** 1-833-850-6076