gpm group benefits

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SHORT-TERM DISABILITY CLAIM
Plan Administrator Form

Group Name ______ **Group No.** ______ **GPM User ID** ______

INSTRUCTIONS

1. **FILL IN THE FORM.** Please complete this form in its entirety in order to avoid delays.
2. **SIGN THE FORM.**
3. **PLEASE SEND THE EMPLOYER'S FORM, THE EMPLOYEE'S FORM AND THE PHYSICIAN'S FORM WITHIN 30 DAYS.**
4. **PLEASE FAX THIS FORM TO 450.667.7739** (along with any information supporting the claim).

Employer information

A copy of all communications related to the present claim will be forwarded to the contact person.

Company Name

Contact Person's Family Name(s) and Given Name(s)

Contact Person's Phone No.

Ext.

Contact Person's Email Address

Participant information

In order to proceed with this claim GPM must receive the employer's form, the employee's form and the physician's form within 30 days.

Participant's Family Name(s)

Participant's Given Name(s)

Date of Birth (d/m/y)

Job Title

Employment information

This section focuses on the participant's employment and on his/her coverage. This section should be completed by the person who best knows these details (for example, the paymaster or the contact person of the plan).

Date of last day of full time duties (d/m/y)

Date of last day of work on modified duties (if applicable) (d/m/y)

Date of return to full-time duties (if applicable) (d/m/y)

Number of hours worked per week, without overtime

Why did the participant stop working

- ○ Accident
- ○ Illness
- ○ Hospitalization

Earnings and Benefits Information

Participant's gross annual salary on the last day of work

Last day paid (d/m/y)

Would you be able to accommodate the participant with modified duties?

- ○ No
- ○ Yes

COMMENTS

EMPLOYER'S AUTHORIZED SIGNATURE

Date (d/m/yyyy)