



Applying for Disability Insurance Benefits FAQ

What is Short-Term Disability (“STD”) Insurance?

- STD insurance provides you with income if you become disabled from working. It generally pays 50-100% of your pre-disability income for up to 6 months, depending on your policy.

What is Long-Term Disability (“LTD”) Insurance?

- LTD insurance provides you with monthly income for a long-standing injury and/or illness, physical and/or psychological. It generally pays 50-80% of your pre-disability income and it is paid for a longer period of time. The age limit for most LTD policies is 65, which means that if you remain disabled from working, you may be entitled to receive these payments for many years.

Am I able to make a claim for STD or LTD benefits?

- To make a claim for these benefits, you must be covered under an applicable insurance policy. You may have coverage through your employer’s group plan or through a private insurance policy. If you are unsure if you have coverage with your employer, you can ask your manager or human resources. If you are disabled from working and have no insurance coverage, you may be eligible for a [government income support program](#).

How do I apply for STD/LTD?

- There are a several steps to complete to apply for insurance disability benefits.
 - 1. Speak with your health care providers to obtain medical support for your application for STD/LTD***

If you do not have medical support, it will be more difficult to get approved.

- 2. Request a copy of the application forms***

This can be done by speaking with your human resources or benefits administrator representative, or by asking your insurance company directly.

3. Complete and submit your portion of the application form

Every application for disability has an [Employee Statement/Notice of Claim](#) form that you, yourself, will need to fill out. In addition, there is a portion for your doctor and a portion for your employer, as discussed directly below.

4. Encourage your doctor to complete their application section (and your employer, if applicable)

Your application will also contain an [Attending Physicians Statement](#), or a form that your primary health care provider will need to complete. You should ensure that your physician completes this in a timely matter.

If your benefits are provided by your employer as part of your group benefits, your employer will need to fill out an [Employer Statement](#) as well.

An application is only considered complete once the insurance company has received all of the previously described portions of the application.

5. Participate in the insurance companies' assessment process

Your assessment process may look different than others, and that is okay. You may be required to participate in a telephone interview in which your insurer will ask you information regarding your health, your daily activities, your work duties, and more. Your insurance company may also ask follow-up questions of you or your doctors. The sooner your insurer completes their assessment, the sooner you will get a decision if your application is approved or denied.

What does the application package look like?

Employee Statement/Notice of Claim Form

This is the form that you fill out about yourself. You generally must disclose personal information relating to your health, disability, limitations, daily routines and more. If you run out of room when providing your answers on the application page, you can attach additional pages. You will want to ensure that you create a narrative and explain why you are unable to work due to your illness and/or injury.

It is very important that you answer all the questions honestly, accurately, and to the best of your ability.

Attending Physician's Statement

This is the form that your healthcare provider will fill out on your behalf. It is important that your doctor answer all of the questions and [provide detailed responses](#).

It is common for applications to be denied due to lack of medical evidence of disability. This often happens when the answers lack specific information relating to your health. An example of this would be a blanket statement such as "*this patient is unable to work at this time due to a medical issue*". If your physician is unsure about how to complete this process, they can contact us and we are happy to speak with them, confidentially and at no cost to you or them.

Employer/Plan Sponsor Statement

If your benefits are provided as part of your group benefits, this is the form your employer must fill out for you as part of your LTD application.

It is important to note that you do not have to share all the medical information relating to the reason you are making a claim for disability benefits with your employer. Your employer only has the right to know [specific information](#).

If you have a private policy, you will not have to fill this form out.

How long will it take for the insurer to assess and decide on my claim?

- Unfortunately, there is no set deadline or timeline of how long this process takes. Often, the assessment period for STD benefits is quicker than LTD and may be approved or denied within a week or two.
- For LTD benefits, it is not uncommon for the assessment process to take anywhere from 2-8 weeks. Your insurer generally must receive all sections of the completed application before they can review and assess your claim. If they need to request more medical information, the assessment process can be delayed.
- If your insurer has not yet decided after 8 weeks, and they received all the requested information, you should contact us ASAP so we can inform you of your options and next steps.

What happens if my claim is accepted?

- If your claim is approved, congratulations, that is great news! Your insurer will provide you with written notice that your application has been successful. In that written document, they will also likely provide the breakdown calculation of your benefit amount and explain any next steps or obligations you should be aware of.
- Still, if there are any issues or red flags that arise while your insurer is handling your claim, please do not hesitate to contact us to get an opinion as to how best to manage your situation. It is not uncommon for insurers to do things that do not necessarily accord with best practices.

What happens if my claim is denied?

- If your claim is denied, we understand just how frustrating and disheartening that can be, but you are not alone. Your insurance company will likely tell you over the phone, and/or provide written notice as to why they are denying that claim. Your insurer will likely tell you about their [appeal processes](#). Our advice is that you absolutely should **not** appeal before speaking with us. Generally, appeals result in delays upon delays, and denials tend to be the common result. There are often better options than appealing, and we can help you understand what these options are. Again, there is no cost to speaking with us and understanding your rights.

Are STD/LTD claim denials common?

- Unfortunately, yes. It is very common for insurers to deny LTD claims when applications are first submitted. There are several [common reasons](#) insurers give to support their decision for denying an LTD application. Our experienced disability lawyers have the knowledge to fight these insurer denials and we have an extremely high success rate in forcing insurers to pay benefits and settle claims that have been unjustly denied.

Questions? Concerns? Contact us!

Toll Free: 1-855-821-5900

Email: help@disabilityrights.ca

www.Disabilityrights.ca

or

Post your question and get an answer from one of our disability lawyers at

www.MyDisabilityQuestions.com

FREE CONSULTATIONS

The information provided in this FAQ document is for general purposes only and should not be relied upon in specific cases without consulting a legal team member at Samfiru Tumarkin LLP. For more information, please contact us at:

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