Regina Civic Employees' Long-term Disability Plan
Authorization & Understanding Form

SECTION 1 – Policy #			
Policy # 33108			

SECTION 2 – Member Information – please print

LAST Name:	*FIRST* Name & Initial:		*Telephone #:*
Mailing Address:	*City/Town:*	*Prov.:*	*Postal Code:*
Birth Date: DD/MM/YEAR	*Email Address:*		

SECTION 3 – General Information

As a member of the Regina Civic Employees' Long Term Disability Plan (hereinafter called "the Plan"), you may be eligible to receive disability benefit payments from the Plan during specific periods of your absence from work.

In order to ensure the Plan is able to coordinate your medical documentation, assist with diagnostic testing, assessments, expediting of surgery, if required, and return-to-work planning, we ask that you please complete this *Authorization & Understanding Form*.

If you have any questions or concerns, please contact Employee Rehabilitation Officer – Tracey Halvorson, at (306) 777-7508 or via email, thalvors@regina.ca.

SECTION 4 – Member Authorization & Understanding

By signing this *Authorization & Understanding Form*, I agree to authorize the Plan to, for the purpose of their administration of my claim for disability benefits, request any information, including all medical documentation, from their respective claim files that pertains to my claim for disability benefits with the Plan.

Also, by signing this *Authorization & Understanding Form*, I acknowledge when a waiver of premium for group insurance is being pursued, this information may also be released to the insurance carrier of said insurance.

Additionally, by signing this *Authorization & Understanding Form,* I authorize the release of my medical documentation to a treating physician, therapy team, assessment facility or any other person/facility involved with the clarification of restrictions and limitations as it pertains to my ability to return-to-work or to assist in the expediting of medical appointments including but no limited to diagnostic or surgical intervention.

____________________	____________________________	_________________________
Date	*Employee's Signature*	*Witness*

***Note*: Once duly completed and signed, please return this form to the address indicated below.**

All personal information collected will only be used for the purposes of administering your benefits under the Plan.

Phone
(306) 777-7402

Fax
(306) 777-6912

E-mail
pensions@regina.ca

Mail
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P.O. Box 3030
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