Ontario Nurses' Association

Long-Term Disability: Grievance Questionnaire

** To be completed by the Grievance Committee and the member

ONA GEL File #: _____ **Grievor Name:** _____

Bargaining Unit Grievance #: _____ **Employer:** _____

Introduction

A grievance has been filed alleging denial or termination of long-term disability (LTD) benefits. This questionnaire asks for facts about the situation, and for some documents. The information will be used to assess the best way for the Ontario Nurses' Association (ONA) to assist in resolving this conflict.

Please note that this is the first of many forms to be completed in conjunction with an LTD grievance and appeal. The LRO (LRO) assigned to the appeal process will provide the other forms after talking with the member. The LRO will also request a number of documents and other information.

Provide a completed copy of this questionnaire to the LRO along with the grievance form.

1. Background Information

(a) What is the name of the insurance carrier? _____

(b) Were the member's LTD benefits:

☐ Denied; payment should have started: year: _____ month: _____ day: _____

☐ Suspended; effective: year: _____ month: _____ day: _____

☐ Terminated after _____ months, effective: year: _____ month: _____ day: _____

(c) What reasons did the carrier give for its actions? *(attach the carrier's letter)*

_____

(d) Which of the following did the member receive? *(please check all that apply)*

☐ Short-term disability

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

☐ Sick pay (accrual type)

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

☐ Combination of Weekly Indemnity (WI) & Employment Insurance (EI)

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

☐ Weekly Indemnity

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

☐ Employment insurance

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

(e) What was the first shift the member missed because of this disability?

year: _____ month: _____ day: _____

(f) Has the member worked for the employer since then?

☐ not at all *(Go to question 2.)* ☐ occasional days only *(Go to question 2.)*

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

from year: _____ month: _____ day: _____ *to* year: _____ month: _____ day: _____

2. The member's action in response to the carrier's decision

(a) Has the member appealed the denial or termination of the long-term disability benefits?

☐ No *(Go to question 3)* ☐ Yes

(b) Who wrote the appeal? (e.g., self, friend, family member, lawyer...):

_____

(c) The "appeal" consisted of:

☐ A discussion of why the carrier's decision is wrong

☐ An explanation of why the member needs the benefits

☐ A discussion of why the carrier should approve the claim

☐ New, supporting medical evidence

What type of evidence was it? *e.g., test results, radiology reports, physician's narrative report*

_____

(d) The appeal was:

☐ Decision has not been received

☐ Granted in part

☐ Denied. What reasons did the insurance carrier give? *(attach the carrier's letter)*

_____

3. Pre-disability Work

(a) In what area did the member work before the illness or injury? *For example, Cardiac, ICU, Neonatal, General Med, Occ Health, Resident Care, Home Visits, Healthy Babies?*

_____

(b) What kind of work did the member do before the illness or injury? Give details about activities, duties, patient/client/resident load, workload in the area, equipment available and used, physical requirements of the area of work, etc.?

_____

(c) How many hours did the member work before sick leave began?

_____ hrs/pay period

(d) Which of the following did the member work as part of her or his normal schedule?

☐ days ☐ weekends
☐ evenings ☐ extended tours
☐ nights ☐ other: _____

4. Restrictions and Limitations

(a) Does the member currently have any medically established limitations or restrictions?

☐ No *(Go to question 5)* ☐ Yes

(b) If yes, what are they? *(attached the statement of limitations/restrictions)*

_____

(c) When were they established? year: _____ month: _____ day: _____

(d) Who set them?

☐ The member ☐ The member's doctor ☐ WSIB
☐ An independent clinic/expert ☐ Occ Health Dept. ☐ The carrier

(e) Is the employer aware of these limitations or restrictions?

☐ No ☐ Yes ☐ Don't know

5. Rehabilitation, Return to Work and Accommodation Issues

(a) Has the member received medical clearance to return to work?

☐ No ☐ Yes

i) Is the member medically able to return to work in her or his own unit, with or without changes to duties, hours of work, or schedule?

☐ No ☐ Yes

What other units, areas, or worksites might be suitable, given the member's limitations and restrictions?

_____

ii) Has this been communicated to the employer yet?

☐ No ☐ Yes

If not, please explain why:

_____

(b) Has the insurance carrier contacted the member about rehabilitation?

☐ No ☐ Yes

(c) Is the member working now?

☐ No *(Go to question 5[g])* ☐ Yes

(d) If yes, in what unit, area, site, program, etc.?

_____

(e) Is this where the member was working before the disability began?

☐ No ☐ Yes

(f) Is this a modified work position?

☐ No *(Go to question 5[g])* ☐ Yes

If yes, how have the member's *duties* been modified? Please summarize the changes.

_____

Was the insurance carrier involved in efforts to modify the position? ☐ No ☐ Yes

Was ONA involved in efforts to modify the position? ☐ No ☐ Yes

Did ONA agree with the modifications? ☐ No ☐ Yes

If not, has the employer been told of ONA's objections yet? ☐ No ☐ Yes

If yes, who was told? _____

What was this person's response?

_____

(g) Have the member's *hours of work* been changed?

i) ☐ No ☐ Yes. Hours are increasing gradually.

☐ Yes ☐ Hours are now: _____ hrs/pay period

ii) Has the member's *schedule* been changed?

☐ No ☐ Yes

The member ***cannot*** work *Please check all that apply:*

☐ days ☐ evenings ☐ nights ☐ weekends ☐ extended tours

☐ other; please explain:

_____

(h) Has the employer offered modified work?

☐ No *(Go to question 6)* ☐ Yes

i) Please describe the modified work offered:

_____

ii) Does this modified work fit the member's limitations/restrictions?

☐ No

☐ Not applicable *(Member has no known limitations or restrictions)*

☐ Yes

(i) Did the employer give the member a physical demands analysis for any jobs in the facility?

☐ No ☐ Yes

6. Disability and Treatment

(a) The member's level of disability has:

☐ been getting better

☐ been getting worse

☐ remained about the same

(b) Was the member receiving treatment for her or his disability before benefits were denied or terminated?

☐ No ☐ Yes

(c) Is the member receiving treatment *now*?

☐ No ☐ Yes

Remind the member of her or his duty to notify the employer of any change in status. The member should do so in writing, keep a copy, and give ONA a photocopy.

Advise the member that the insurance policy requires that a claimant be under continuous, active, appropriate medical treatment. Failure to do so is grounds for denying, suspending, or terminating benefits.

7. Prognosis

(a) What is the member's prognosis?

☐ may never be able to work in any capacity

☐ will probably never be medically able to return to work in the pre-disability job

☐ will probably be medically able to return to work within _____ weeks

☐ will probably be medically able to return to work within _____ months

☐ is medically able to return to work now.

(b) This prognosis is based on the opinion of:

☐ the member alone

☐ the member, reporting what she or he was told by:

☐ her or his family physician

☐ a specialist involved in diagnosing or treating the member

☐ a specialist or clinic *not involved in diagnosing or treating the member*

8. The Insurance Carrier and the Member since Benefits were Denied or Terminated

(a) Have the carrier and the member communicated since the carrier sent notice of its decision?

☐ No *(Go to question 9)* ☐ Yes

(b) The communications pertained to: *(Check all that apply)*

☐ providing more medical evidence

☐ giving the insurer reasons for changing its decision

☐ rehabilitation

☐ attending an assessment or examination of the insurer's choosing

☐ returning to work

☐ settling for a lump-sum payment or limited term of benefits

☐ other; *please explain*:

_____

(c) Has the insurance carrier required the member to see a doctor or other health practitioner of its choice for testing or examination?

☐ No *(Go to question 9)* ☐ Yes

Has the member complied with the insurance carrier's request?

☐ Yes; testing or examination was done: year: _____ month: _____ day: _____

☐ Not yet; one is scheduled for: year: _____ month: _____ day: _____

☐ No. Please explain why not.

_____

(d) Has the insurance carrier required the member to participate in a Functional Abilities/ Capacities Assessment?

☐ No *(Go to question 9)* ☐ Yes

Has the member complied with the insurance carrier's request?

☐ Yes; testing or examination was done: year: _____ month: _____ day: _____

☐ Not yet; one is scheduled for: year: _____ month: _____ day: _____

☐ No. Please explain why not.

_____

9. <u>Compensability under the *Workplace Safety and Insurance Act*</u>

(a) Is the injury or illness work related?

☐ No *(Go to question 10)* ☐ Yes

(b) Has the member applied for Workplace Safety and Insurance Board (WSIB) benefits?

☐ No ☐ Yes; benefits were: ☐ approved ☐ denied

(c) Has the member met with the employer?

☐ No ☐ Yes

If yes, please summarize the meeting. What was discussed? What, if anything, was proposed and by whom? What was accomplished, if anything?

_____

(d) Did the employer give the member a physical demands analysis for any jobs at the facility?

☐ No ☐ Yes

(e) Has the member met with the Workplace Safety and Insurance Board caseworker?

☐ No ☐ Yes, on: year: _____ month: _____ day: _____

(f) Has the member had a Workplace Safety and Insurance Board Labour Market Re-entry (LMR) assessment?

☐ No ☐ Yes

Has she or he met with a Workplace Safety and Insurance Board LMR provider?

☐ No ☐ Yes, on: year: _____ month: _____ day: _____

(g) Did the Workplace Safety and Insurance Board determine medical restrictions?

☐ No ☐ Yes *(please attach a copy)*

(h) Is any aspect of the member's WSIB claim in dispute?

☐ No ☐ Yes

Who is appealing WSIB's decision? ☐ the member ☐ the employer

Who is assisting the member? ☐ ONA ☐ an outside rep. ☐ no-one

Attach any completed WSIB Functional Abilities for Timely Return to Work Form

10. Income Sources

Following is a list of *possible income sources* for which the member may be eligible.

For each, please check whether she or he is receiving income from this source, and answer the rest of the applicable questions for this income source.

(a) **WSIB/Workers' Compensation Board (WCB)**

Is the member in receipt of WSIB/WCB benefits?

☐ No: Did the member apply: ☐ No

☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: Benefit period start date: year: _____ month: _____ day: _____

end date: year: _____ month: _____ day: _____ or ☐ continuing

(b) **Employment Insurance**

Is the member in receipt of Employment Insurance sick benefits?

☐ No: Did the member apply: ☐ No
☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: Benefit period start date: year: _____ month: _____ day: _____
end date: year: _____ month: _____ day: _____ or ☐ continuing

(c) **Group Insurance** *other than through the employer*

Is the member in receipt of group insurance benefits?

☐ No: Did the member apply: ☐ No
☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: Benefit period start date: year: _____ month: _____ day: _____
end date: year: _____ month: _____ day: _____ or ☐ continuing

(d) **Private Insurance** *purchased under an individual policy*

Is the member in receipt of benefits from private insurance?

☐ No: Did the member apply: ☐ No
☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: Benefit period start date: year: _____ month: _____ day: _____
end date: year: _____ month: _____ day: _____ or ☐ continuing

(e) **Canada Pension Plan**

Is the member in receipt of Canada Pension Plan benefits?

☐ No: Did the member apply: ☐ No
☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: type of pension ☐ disability ☐ retirement
Benefit period: start date: year: _____ month: _____ day: _____
end date: year: _____ month: _____ day: _____ or ☐ continuing

(f) **Employer-sponsored pension plan (e.g., Healthcare of Ontario Pension Plan [HOOPP] or Ontario Municipal Employees Retirement System [OMERS])**

Does your employer-sponsored plan offer disability benefits? ☐ No ☐ Yes

Is the member in receipt of benefits from your employer-sponsored pension plan?

☐ No: Did the member apply: ☐ No
☐ Yes. Status of application: ☐ denied ☐ not decided yet

☐ Yes: type of pension ☐ disability ☐ retirement
Benefit period: start date: year: _____ month: _____ day: _____
end date: year: _____ month: _____ day: _____ or ☐ continuing

(g) **Payments from insurance arising from an automobile accident**

☐ Not applicable

☐ No, the case has not been resolved yet

☐ Yes ☐ Income replacement benefits ☐ Damages

☐ Reimbursement for legal/medical expenses

(h) **Ontario Disability Support Program Benefits (ODSP)**

Is the member in receipt of ODSP benefits?

☐ No: Did the member apply: ☐ No

☐ Yes. Status of application: ☐ denied ☐ not decided yet

(i) **Ontario Works ("welfare")**

Is the member in receipt of Ontario Works benefits?

☐ No: Did the member apply: ☐ No

☐ Yes. Status of application: ☐ denied ☐ not decided yet

Advise the member to:

☐ 1. Keep a chronology of events since the start of her or his absence from work, with dates, names, and what was said, such as:

- correspondence with the insurance carrier.
- telephone conversations with the insurance carrier's claims adjudicators.
- meetings with the insurance carrier's rehab representative.
- discussions by phone or at a meeting with the employer.

☐ 2. Keep a diary of medical events since the injury occurred or the illness began, such as:

- appointments for medical, diagnostic or treatment purposes.
- medications and their starting date, dosage, effectiveness and side-effects (if any).
- other treatments: the types, dates, and effectiveness.
- diagnostic tests and their results.
- improvement or deterioration, and the approximate date it started.

☐ 3. Arrange an appointment with her or his physician for an update on her or his status.

☐ 4. Maintain regular visits with her or his doctor.

☐ 5. Notify the Grievance Committee every four to six weeks about whether her or his condition has changed, and whether she/he is back at work. This must be done in a way that maintains the member's medical and other privacy. The member should keep a copy of each message.

☐ 6. Call the Grievance Committee if she/he has any questions.

☐ 7. Notify the carrier of any change in the severity of the disability and of any change in income.

☐ 8. Contact the Grievance Committee *immediately* if the employer asks to meet with her/him.