



## Notice of Long Term Disability (LTD) Claim Form

**\*Please answer all questions carefully and completely as this will assist us in providing you the best possible service\***

This form should be completed in ink (please print) and mailed, faxed or emailed to:

**Unistar Special Risks Inc. Attn: Underwriting**  
**850, 10655 Southport Road SW**  
**Calgary, AB T2W 4Y1**

**Email: [underwriting@unistarinc.ca](mailto:underwriting@unistarinc.ca)**  
**Fax #: 1-800-364-0754**

\*Early filing of the Notice of Claim will help expedite the claims process\*

**Employer / Policyholder:** \_\_\_\_\_

Employer/Policyholder Address: \_\_\_\_\_  
Street City, Province Postal Code

Employer/Policyholder Contact Name: \_\_\_\_\_

Employer Email Address: \_\_\_\_\_ Telephone No.: ( \_\_\_\_\_ ) \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ **Date of Birth:**          **D** **M** **Y**

Employee's Home Address: \_\_\_\_\_  
Street City, Province Postal Code

Employee's Email Address: \_\_\_\_\_ Telephone No.: ( \_\_\_\_\_ ) \_\_\_\_\_

Employee's Occupation: \_\_\_\_\_ Class / Division: \_\_\_\_\_

**Employee's Last Day Worked:**          **D** **M** **Y**

Is this absence due to a work-related injury?  Yes  No *If Yes, please provide details:*

Date of Incident/Accident:          **D** **M** **Y** Place of Accident: \_\_\_\_\_

Circumstances of Incident: \_\_\_\_\_

*Details of person completing form:*

Relationship to Employee/Member (Please check below):

Employer / Policyholder  Broker  Insured  Other: \_\_\_\_\_

Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

(Please Print)

Signature

Date

<b>For office use only :</b> <small>*Do not write in this box*</small>  Initials: _____  Date Reported (to Western Life): <u>  </u> <u>  </u> <u>  </u> <b>D</b> <b>M</b> <b>Y</b>	<b>Western Policy Number:</b> _____	<b>Cert/Div#:</b> _____
	<b>TPA:</b> _____	<b>TPA Contact:</b> _____
	<b>TPA Email:</b> _____	
	<b>Insured Monthly Benefit:</b> _____	<b>Non-Evidence Max:</b> _____
	If coverage over NEM, was excess medically underwritten: <input type="checkbox"/> Yes (please attach form) <input type="checkbox"/> No, coverage grandfathered <input type="checkbox"/> N/A, under NEM	
Unistar LTD inception date: _____		
LTD coverage prior to Unistar? <input type="checkbox"/> No <input type="checkbox"/> Yes: Carrier: _____		
PC LTD effective date: _____		
Is Life coverage for this group with Western Financial?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is Unistar currently managing a Short Term claim for this absence? <input type="checkbox"/> Yes <input type="checkbox"/> No		