



Memo to colleague absent due to disability

You make an essential contribution to your employer's success through your daily work. When you are absent, your manager has to make adjustments in work assignment. As a result, any information your physician can provide as to your eventual return to work, either full-time, part-time, or with restrictions during recovery, will be very useful.

To be eligible for benefits under the Disability plans, you must comply with the following requirements.

IMPORTANT: Failure to do so may result in suspension of disability benefits.

- Medical reports:**
- COMPLETE the first section of the attached ATTENDING PHYSICIAN'S STATEMENT before submitting it to your treating physician or specialist, as the case may be.
 - Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.
 - Return the completed and signed ATTENDING PHYSICIAN'S STATEMENT Form to Acclaim by fax at 1-866-486-8663_or by email to medical@acclaimability.com (or ensure the physician or specialist does so).

- Medical treatment:**
- You must follow medical advise and any reasonable prescribed treatment
 - You must be under the care of a regulated healthcare practitioner in Canada.

- Acclaim:**
- Acclaim may contact your treating physician or specialist, or may contact you, to obtain additional information on your medical condition, treatments and stage of recovery.
 - Acclaim may ask you to see a designated consulting physician to confirm a diagnosis, prescribed treatment, and estimated duration of restrictions. Failure to attend or to cooperate with the exam without a valid reason may result in suspension of your accommodation.

Confidentiality: All personal health information (PHI) such as the diagnosis/medical condition is confidential. Acclaim will only provide information such as the medical limitations and recommended accommodation to American Express.

Healthy Minds Program (EFAP)

Holistic well-being, including mental health, is a top priority at American Express. American Express colleagues and their household members have access to 10 free counseling sessions through Healthy Minds. To learn more visit, amex.lyrahealth.com or call 1-800-874-3817.

Communication: If you plan on travelling or residing somewhere other than your primary residence during your medical absence from work, you must give at least one week's notice to Acclaim and your employer will be notified. Failure to comply with this condition may result in suspension of benefits.

- Responsibility:**
- You should follow the advice of your treating physician and/or Acclaim Ability and take steps to ensure a quick and complete recovery.
 - Performing activities that are incompatible with your disability or working at other employment may result in the suspension of benefits.
 - You are responsible in remaining under the regular care of a physician to update your medical status and discuss health related concerns associated with a successful return to work.
 - All treatment plans recommended by the treating physician must be adhere to; failure to do so may result in a suspension of benefits.
 - Ongoing communication between you and Acclaim Ability is fundamental in expediting a successful recovery and a smooth transition back into the workforce.

Light or modified duty: If you are medically approved to perform light or modified duties, your HR representative and manager / supervisor will do what they can to accommodate your return depending on the availability of light or modified duties.

Cost of completion of forms: All costs associated with the completion of any medical forms related to your STD claim are the responsibility of you, the Colleague.





**SHORT TERM DISABILITY BENEFITS - ADVANCE PAYMENT RECOVERY FORM
EMPLOYEE CONSENT AND AUTHORIZATION**

To: Amex Canada Inc. ("Amex") Payroll Department

Re: Short Term Disability ("STD") Advance Payment

Under the provisions of Amex's STD policy, I _____, acknowledge that once I have been absent from work for more than my regularly scheduled workweek, Amex will pay me employment income based on the STD Schedule of Benefits in advance of me qualifying for and being approved for STD benefits in order to minimize disruption to my finances during the STD approval process with Sun Life Assurance Company of Canada ("Sun Life"). This payment is referred to as the "Advance Payment." **To receive the Advance Payment, I agree to complete this authorization form and return it via fax to Sun Life (1-866-639-7851) or email disabilityclaims@aexp.com.**

In the event my short-term disability claim is not approved following review by Amex's STD administrator, Sun Life, I agree and consent to refund to Amex the Advance Payment.

Therefore, by signing this form, I acknowledge and agree that, if my application for STD Benefits is **not approved**:

- (a) I must reimburse Amex the Advance Payment as defined above;
- (b) I expressly consent and authorize Amex to withhold and deduct from my wages an amount equal:

Overpayment Amount	# of Pay Periods	
< \$500	1	Pay Period
\$501 - \$1,000	2	Pay Periods
\$1,001 - \$2,000	3	Pay Periods
\$2,001 - \$5,000	4	Pay Periods
> \$5,001	5	Pay Periods

Where the Advance Payment is to be repaid over several pay periods, the total amount to be repaid by me will be divided by the number of pay periods over which it will be deducted. By way of example, if \$2,500 is to be repaid, \$625 will be deducted from each payroll.

Please note if a repayment would flow into the following calendar year, I will be required to participate in an accelerated repayment schedule to ensure overpayments are collected in the same calendar year as the advance payment. This is to prevent revisions or errors in Records of Employment or T4 forms. Amex may be prepared to extend the repayment into the following year, at its discretion, in special circumstances.

Provided that my employment continues with Amex during the STD appeal process, these deductions will not occur until the exhaustion of my STD appeal period as set out in Amex's STD Policy; and

(c) I expressly consent and authorize Amex that should my employment with Amex terminate prior to the repayment of the Advance Payment by installments, to withhold and deduct from my wages or any other amounts owing to me, including and termination/severance pay, accrued vacation pay, an amount equal to the full Advance Payment then outstanding, as permitted by applicable employment standards legislation.

I acknowledge and agree that a photocopy of this authorization or electronic version is as valid as the original; and I am signing this authorization voluntarily and have reviewed this authorization and comprehend fully the terms and conditions contained herein. I also understand and agree that this document will be shared with an administrative function of Amex based in the U.S.

DATED AT _____ ON THIS ____ DAY OF _____ YEAR _____.

Name of Employee _____

Signature of Employee _____



Address of Employee _____

Sun Life Contract Number **101696**

Employee Certificate Number _____



ATTENDING PHYSICIAN STATEMENT

(Medical Form)

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

Employee Name _____ Phone No. _____
(Last name first, in full)

Address _____
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: _____ Language: E F Other
Day Month Year

I have access to a printer and am able to print all required medical forms: Yes No Email Address: _____

Check ONE: Left Hand dominant or Right Hand dominant or Ambidextrous

Were you hospitalized? Yes No

If YES, name of the hospital/institution _____ from |_|_|_|_|_|_|_|_| to |_|_|_|_|_|_|_|_|_|
Day Month Year Day Month Year

Are you claiming or receiving any other disability, wage loss and/or retirement benefits (e.g. WSIB, CPP/QPP, auto insurance, other)? Yes No

Are you working or volunteering in any capacity? Yes No

Are you receiving wages from any source? Yes No

Are you attending any educational course, program or institution? Yes No

If yes to any of the above, please provide details of these items on a separate page and include any confirming documents, claim numbers, etc.

If an accident caused your disability, indicate date |_|_|_|_|_|_|_|_|_|, WHERE and WHAT happened:
Day Month Year

AUTHORIZATION

I, _____ hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, to release to Acclaim Ability Management ("Acclaim") or its representatives or agents, any and all medical, employment or vocational information or records with respect to my claim for short-term disability benefits, including any appeal I might institute ("STD benefits") and for the purpose of Acclaim's evaluation, administration and management on behalf of my employer in relation to my medical absence from work from American Express, including assessing my ability to return to work and my potential need for accommodation. I further authorize Acclaim or its representatives or agents to disclose any such information obtained in respect of my STD claim to any physician, clinic or any other medical or health care provider or facility for such purposes. I declare that the information provided in this authorization and any statements provided in any personal interview relating to my STD claim are/will be true, complete and accurate. In the event I do not return to work and I submit an application for long term disability ("LTD") benefits to SunLife, I understand and authorize that all documents contained in and that are relevant to my entire STD claim file will be disclosed to SunLife and will form part of my LTD file.

This authorization shall remain valid for the duration of my claim with Acclaim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original. I understand that my refusal or withdrawal of consent may delay the provision or result in the denial of my STD claim.

Employee Name (Printed)

Employee Signature

Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

The patient is responsible for any charges made for completion of this form, unless prohibited by law. Please return completed form to your patient.

ILLNESS INFORMATION

Nature of the illness or injury: _____

Date illness or injury began: _____ Date of examination by Physician: _____

Date deemed unable to work: _____

Is there a medical treatment plan currently in place? Yes No If no, why? _____

Is the employee compliant with the prescribed/recommended treatment plan? Yes No

If employee cannot return to full duties, can the employee return to work on modified duties: Yes No Date: _____

If **yes**, please describe the employee's current limitations (please use the abilities section if applicable) If **NO**, please provide the medical contraindications to a modified return to work:

Expected length of time modifications will be required: _____

Is this injury or illness work related: Yes No Has a Physician's Initial Report been submitted to WCB? Yes No

If disability is related to pregnancy, please indicate the expected date of delivery _____
Day Month Year

I see the patient every _____ (day, week, etc.) Date of most recent examination _____
Day Month Year

Has patient ever had a similar condition? Yes No **If yes, state when and describe:**

FUNCTIONAL ABILITIES:

- Walking (continuously): up to 30 min; up to 1 hour; no restriction; Other (e.g. uneven ground) _____
- Standing (continuously): up to 30 min; up to 1 hour; no restriction; Other _____
- Sitting (continuously): up to 30 min; up to 1 hour; no restriction; Other _____
- Lifting floor to waist: up to 20 lbs; up to 30 lbs up to 40 lbs; no restriction; other _____
- Lifting waist to shoulder: up to 20 lbs; up to 30 lbs up to 40 lbs; no restriction; other _____
- Carry: up to 20 lbs; up to 30 lbs up to 40 lbs; no restriction; other _____
- Push/Pull: up to 20 lbs; up to 30 lbs up to 40 lbs; no restriction; other _____
- Stair climbing: unable 2 – 3 steps only; own pace assisted no restriction
- Ladder climbing: unable 2 – 3 steps only; own pace assisted no restriction
- Able to drive up to 2 hours up to 4 hours; no restriction other _____
- Able to operate heavy machinery: up to 2 hours up to 4 hours; no restriction other _____
- Employee is: Left handed Right handed Ambidextrous
- Limited ability to used **left** hand to: hold objects; grip; type; write
- Limited ability to used **right** hand to: hold objects; grip; type; write
- Completely unable to use **left** hand to: hold objects; grip; type; write
- Completely unable to use **right** hand to: hold objects; grip; type; write
- Hours per day: 4 hours 6 hours 8 hours 10 hours 12 hours no restriction

Employee Name:

American Express

COGNITIVE ABILITIES:

Deadline Pressures:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Attention:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Memory:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Reasoning:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Problem Solving:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____

Other clinically assessed limitations: _____

If Nature of condition is Psychological/Mental Health, please advise if criteria for ICD -10- CM/ DSM 5 was evaluated:

Yes No

Treatment

If hospitalized, name of the hospital/institution _____ from _____ to _____
Day Month Year Day Month Year

Surgery? Yes No (if yes, state surgical procedure) _____

Performed Planned Date of Surgery _____ Anesthetic: Local General
Day Month Year

List medications currently prescribed and dosage _____

Therapy? Yes No If yes, indicate type (e.g. physiotherapy, psychotherapy, etc.) _____

Frequency: Daily _____ x per week Other _____
Location: Outpatient Therapist's Office Physician's Office Home

Summary of patient's response to treatment:

Prognosis

Have you discussed a Return to Work Plan with your patient? Yes No

If no, why not? _____

If yes, please provide details about the Return to Work Plan including recommendations for modified hours and/or modified duties:

Expected date of Return to Work Full-Time _____ Next appointment: _____
Day Month Year Day Month

Year

Additional Comments:

Employee Name: _____

American Express

ATTENDING PHYSICIAN'S INFORMATION

NOTICE TO PHYSICIAN: Any information provided by you to **Acclaim Ability Management** regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Physician's Name (please print): _____ Telephone: _____

Address: _____ Fax: _____

Signature: _____ Specialty: _____ Date: _____