



Memo to employee absent due to disability

You make an essential contribution to the Company'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.

Labatt also requires that you comply with following conditions and processes. **IMPORTANT:** Failure to comply may result in the suspension of your disability benefits.

Medical reports:

- a) 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.
- b) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.
- c) 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) within 14 calendar days of submitting referral.

Medical treatment:

- a) You must receive appropriate MEDICAL treatment during your absence.
- b) Initial treatment should be provided by a qualified medical practitioner. Treatment by a health care practitioner other than a physician—a chiropractor or psychologist, for example—is acceptable on the condition that a diagnosis has first been made by a qualified medical practitioner and that the nature and duration of the treatment have been specified by this physician.

Acclaim:

- a) During your absence, 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. Failure to respond/follow-up or provide the additional information may result in suspension of your disability benefits.
- b) During your absence, Acclaim may ask you to see a designated consulting physician to confirm a diagnosis, prescribed treatment, estimated length of absence or restrictions. Failure to attend or to co-operate with the exam without a valid reason may result in suspension of your disability benefits.

Confidentiality:

All personal health information such as the diagnosis/medical condition is confidential. Only information such as the expected return to work date/work restrictions are provided to Labatt by Acclaim.

Employee and Family Assistance Program (EFAP)

Short-term counselling services are available on a confidential, voluntary basis to Labatt Brewing Company employees experiencing personal difficulties.

This service can be reached through Sun Life Lumino Health Virtual Care by dialling 1-844-342-3327 Or visit the website at luminovc.dialogue.com

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 two weeks' notice to your Wellness Team wellnessteam@labatt.com, who will request medical advice from Acclaim. Failure to comply with this condition may result in suspension of benefits.

Responsibility:

- a) You should follow the advice of your treating physician and/or Acclaim Ability and take steps to ensure a quick and complete recovery.
- b) Performing activities that are incompatible with your disability or working at other employment may result in the suspension of benefits and further actions relating to your employment status with Labatt.
- c) You are responsible in meeting with your treating physician on a regular basis to update your medical status and discuss health related concerns associated with a successful return to work.
- d) All treatment plans recommended by the treating physician must be adhere to; failure to do so may result in a suspension of benefits.
- e) 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, the Company will do what they can to accommodate your return depending on the availability of light or modified duties.



ATTENDING PHYSICIAN STATEMENT (Medical Form)

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

Employee's 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: _____

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 (Name of 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 ("STD benefits", including any appeal I might institute) 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 Labatt Brewing Company, 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 understand that my refusal or withdrawal of consent may delay the provision or result in the denial of my STD claim. I declare that the information provided in this authorization and any statements provided in any personal or telephone 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 Manulife, I understand and authorize that all documents contained in and that are relevant to my entire STD claim file will be disclosed to Manulife and will form part of my LTD file. I acknowledge that the services provided by Acclaim will not in any way be construed as an admission of liability by Manulife or acceptance of a claim for the payment of LTD benefits.

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.

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 totally disabled from 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: _____

Please send completed form to **Acclaim Ability Management** at 1-866-486-8663 or medical@acclaimability.com

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 report been submitted to the Workers Compensation Board? 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 5 kg; up to 10 kg no restriction; other _____

Lifting waist to shoulder: up to 5 kg; up to 10 kg no restriction; other _____

Carry: up to 5 kg; up to 10 kg no restriction; other _____

Push/Pull: up to 5 kg; up to 10 kg no restriction; other _____

Stair climbing: unable up to 3 steps; up to 6 steps; own pace assisted no restriction

Ladder climbing: unable 2 – 3 steps only; own pace assisted no restriction

Travel to work: Ability to use Public Transit YES NO Ability to Drive a Vehicle: YES NO

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 push pull

Limited ability to used **right** hand to: hold objects; grip; type; write push pull

Completely unable to use **left** hand to: hold objects; grip; type; write push pull

Completely unable to use **right** hand to: hold objects; grip; type; write push pull

Hours per day: 4 hours 6 hours 8 hours 10 hours 12 hours no restriction

Please indicate **restrictions that apply:**

Bending / Twisting / Repetitive movement (please specify): _____

Exposure to vibration: Whole body Hand/Arm _____

Work at or above shoulder level: _____

Environmental exposure (i.e. heat, cold, noise, or scents): _____

Chemical Exposure: _____

Overtime NOT restricted (may work more than 40 hours/week): _____

Overtime restricted while on modified work / modified hours: _____

Employee Name:

Labatt Brewing Company

COGNITIVE ABILITIES:

Deadline Pressures: limited capacity unable to perform no restriction; Other _____

Attention: limited capacity unable to perform no restriction; Other _____

Memory: limited capacity unable to perform no restriction; Other _____

Reasoning: limited capacity unable to perform no restriction; Other _____

Problem Solving: limited capacity unable to perform no restriction; 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 not, 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 and Duties _____ Next appointment: _____
Day Month Year Day Month Year

Additional Comments:

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: _____

Please send completed form to **Acclaim Ability Management** at 1-866-486-8663 or medical@acclaimability.com