

Disability, Life & Sickness Insurance and HIV/AIDS

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1. Introduction

Insurance is a promise to provide compensation (money) in the case of a potential future need or loss. It is a form of protection against unexpected events and is financed by a large pool of people who may draw on the pool in specified cases of need or loss. There are some forms of insurance that everyone has to have. For example, every person in Ontario is required to have is insurance for their truck or car. Many forms of insurance, however, are optional. No one is *required* to have life, disability or health insurance, but many people choose to have one or more of these types of insurance to protect themselves and their families in case

they become ill and are unable to work or if they have high drug costs.

People who are HIV-positive often rely on life, disability and health insurance when they need financial assistance due to temporary or long-term periods of poor health. Life insurance provides money to the survivors of an insured person upon their death or may be cashed in for a partial payment when an insured person becomes terminally ill. Disability insurance provides an insured person with an income if they become disabled and are unable to continue with productive work. Extended health insurance covers the cost of medical care according to the personal needs of the individual who is insured and may be used to supplement services not covered under the Ontario Health Insurance Plan (OHIP).

2. Definitions

Application. A statement of information made by a person applying for insurance. It identifies the plan and the amount applied for, the life insured and the beneficiary, and provides other data useful in evaluating the risk.

Beneficiary. The person(s), charity or other organization who is to receive the life insurance proceeds at the death of the insured.

Benefit. The amount payable by the insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy.

Benefits Booklet. A document delivered to an individual that summarizes the benefits and principal provisions of the group contract under which the person is insured.

Claim. A demand to the insurer by the insured person for the payment of benefits under a policy.

Co-insurance/Co-payment. Under many health and dental plans, you may be required to share the cost of eligible expenses covered by the plan. For example, your plan may require you to pay 20% of the eligible cost of your prescription drugs, and the plan pays for the remaining 80%. The amount you pay represents a co-payment.

Conversion option. If you have life insurance through a group employee benefits plan and your coverage ends because you leave your job, you can usually apply to convert your coverage to an individual policy, without providing proof of good health. You must request the conversion within 31 days of the end of your group coverage. A conversion option under health and dental benefit plans is not automatic and is less common, but in some cases you may be able to convert your group health or dental coverage if your benefits are terminated under your group plan. Group disability benefits are usually not convertible to an individual plan when your coverage ends.

Covered expenses. Specified hospital, medical and miscellaneous health care expenses that will be considered in the calculation of benefits due under a health insurance policy.

Death benefit. A payment made to the designated beneficiary or estate when the insured person dies.

Deductible. The amount of covered expenses that must be incurred and paid by you before benefits become payable by the insurer. For example, it's not uncommon for a health plan to have a deductible of \$25, \$50 or \$100 per covered person each year.

Dependants. Group health and dental and some life insurance plans may provide coverage for dependants. Dependants usually include your spouse or common law or same-sex partner and children dependent on you for care, custody and support, within certain age limits. Even spouses who have their own coverage, however, might be considered a dependent on your plan. You could be listed as a dependent on your spouse or partner's plan.

Disability. A physical or mental condition that makes an insured person incapable of performing one or more duties of his or her occupation. Each policy will have its own definition of disability, usually summarized in the benefits booklet. Some policies also use the term "total disability" to define eligibility for disability benefits.

Disability insurance. A form of insurance that provides periodic payments when you are unable to work as a result of illness or injury. To become eligible for a disability insurance benefit, an insured must prove that they are "totally disabled" as defined by the policy.

Effective date of insurance. The date a person becomes insured under a group benefits plan after they have completed the eligibility or waiting period.

Eligibility or waiting period. Most group benefits plans specify a waiting period (e.g. three months) before a new employee is covered under the plan.

Eligible expenses. These are the specified health, vision and dental expenses that are covered under a group benefit plan, most of which must be medically necessary or recommended by a physician. In most cases, you incur the expense and then submit a claim form with attached receipts to be paid back. However, paperless claims are possible under health plans that use drug cards, and dental

plans that permit electronic claims submissions by dentists.

Elimination or qualifying period. Most disability insurance plans include an elimination or qualifying period, which is the period you must be disabled, as defined in your policy, before your benefit payments will begin.

Evidence of insurability. Evidence of insurability is usually required when you are purchasing an individual life insurance policy, when you want to increase your level of disability or life insurance under a group plan, or when you are a late applicant for a group plan. Evidence of insurability usually includes information about your health status and other relevant information, which the insurance company uses to calculate your level of risk in insuring you. Evidence of insurability may include some or all of: a written statement from you, a medical statement by your doctor and/or release of your medical records, examination and statement by independent examiners, x-ray and laboratory test results.

Extended health insurance. A form of health insurance that provides, in one policy, protection for hospital and medical expenses not covered by government programs and usually other health care expenses, such as prescribed drugs, medical appliances, ambulance, private duty nursing, etc. The policy may contain a deductible amount, co-payments, and maximum benefits payable. Also called "*major medical expense insurance*" and "*supplementary health care plans*".

Exclusions – see also Limitations. Most group health plans contain exclusions. These are conditions or situations in which your plan does not cover you. For example, a drug or a treatment that is not medically necessary may be excluded from your benefit plan.

Face amount. The amount stated on the face of the policy that will be paid on the death of the life insured or at the maturity of the policy. It does not include additional amounts payable under accidental death or other special provisions, or acquired through the application of policyholder dividends. Also called the "*sum insured*".

Grace period. The period (usually 30 or 31 days) following the premium due date, during which an overdue premium for a life insurance policy may be paid without penalty. The policy remains in force throughout this period.

Group insurance. Insurance issued, usually without medical examination, on a group of people under a master contract. It is usually issued to an employer for the benefit of employees. The individual members of the group hold certificates as evidence of their insurance.

Individual insurance. Insurance purchased on an individual basis, covering only one person or, in some cases, members of his or her family as well.

Insured. The person who owns an insurance policy. Also called the "*policyholder*".

Insurer. The party to the insurance contract who promises to pay losses or benefits. Also, any corporation licensed to furnish insurance to the public.

Life insurance. Insurance providing for the payment of benefits upon the death, whether by accident or otherwise, of the life insured.

Limitations – see also Exclusions. These are specific restrictions in the plan or policy that determine whether benefits will be paid in full or in part. Detailed information about limitations and exclusions can generally be found in the benefits booklet or insurance

policy. Remember that each policy/plan is different. The formal plan document governs the terms of your coverage, so make sure you review it carefully.

Long-term disability. Long-term disability coverage replaces a portion of your income if you are totally disabled, as defined in your policy/plan, for a period that goes beyond the elimination or qualifying period, and that usually will last as long as you remain totally disabled. Long-term disability payments are usually paid monthly.

Policy. The legal document issued by the insurer to the policyholder that outlines the conditions and terms of the insurance. Also called the plan or the contract.

Policyholder. The person who owns an insurance policy. Also called the "*insured*".

Pre-existing condition. A pre-existing condition is a physical or mental health condition for which you have been diagnosed or received treatment, testing, medical advice or consultation within a specified length of time immediately before becoming insured (usually between 3 and 12 months before the effective date of insurance). If you have a pre-existing condition, your plan may not pay any benefits for a loss that resulted from this pre-existing condition, particularly if the loss occurs during the initial period of your coverage under the plan (e.g. 12 or 24 months). Check your policy to see if this limitation applies and to verify its details.

Premium. The payment, or one of the periodic payments, a policyholder is required to make for an insurance policy. Premiums payable for group insurance policies are often paid, in whole or in part, by your employer.

Short-term disability. Short-term disability plans provide benefit payments for a prescribed period of time to a person who is

disabled due to illness or injury. This may also be referred to as a “*weekly indemnity*”. Short-term disability benefits are usually paid weekly.

Total Disability. Long-term disability plans require that you be “totally disabled” before you can be approved for benefits. Totally disabled means that you are unable to do the elements of your job as a result of your disability.

Waiver of premium. Some insurance policies provide a waiver of premium provision. This means that after a certain period of total disability, you and/or your employer no longer have to make premium payments for the insurance coverage to continue.

3. Where to get information about your insurance coverage

Information about your insurance coverage is contained in the insurance contract, also known as the insurance policy, made between the purchaser of the insurance and the insurer. In some cases, the purchaser will be an individual, in other cases the purchaser may be an employer or union representative who has purchased the insurance on behalf of a specific group (group insurance). It is in your best interest to read the insurance policy carefully, as the policy sets out your coverage and benefit entitlement, and in addition contains information about any limits on your insurance. In the case of group insurance, the group members will not each get a copy of the insurance contract, but details of the benefits and limitations will be contained in the benefits booklet, which must be provided to each member of the group.

3.1 Sources of Insurance

In order to obtain your insurance policy, you must first determine the “nature” or “source” of your insurance. Insurance typically comes from three different sources: group insurance plans, individual insurance plans and government insurance plans.

3.1.1 Group Insurance Plans

Group insurance plans provide insurance coverage for a group of individuals and their eligible family members as defined in the insurance contract. You probably have insurance coverage, if you are employed, through your employer or union. Your spouse, common law or same-sex partner, if he or she is employed, also likely has insurance through their place of employment, and you might be eligible for some benefits under your spouse’s or partner’s plan. This coverage is usually provided through an employee benefit program and is known as group insurance. Professional associations and other groups like alumni associations may also purchase group insurance. You must be a member of a sponsoring association or union to be eligible for group coverage. Coverage ends, for employees, when they leave their place of employment, and for union members, when they cease to be a member of the union. In the case of layoffs and/or downsizing in the workplace, employees may be eligible to continue their coverage for a specified period of time or may be offered replacement coverage.

Typically you must also be a permanent full-time employee to be eligible for a group plan sponsored by your employer. In some cases, there is a probationary period (i.e., three months) that an employee must serve before they become enrolled in group insurance plan sponsored by their employer. Individuals with coverage under a group plan sponsored

by an association usually pay the full cost of the premiums for the insurance. Insurance premiums under an employer or union sponsored plan, are usually paid in full by the employer or the union. Employees may have an option of choosing to pay their own premiums for long-term disability insurance, however, as they are then able to receive the benefits tax-free in the event that they become disabled.

Basic levels of disability insurance, extended health insurance and life insurance are usually provided under group insurance plans. This basic coverage is provided under large group plans (i.e., 25 group members or more) without the employee or association member being required to provide proof of good health. This means that you will be eligible for benefits even if you are HIV-positive.

Employees who are covered under group plans with a small membership (less than 25 group members) may be required to provide detailed information about their health. If you are asked to provide health information and you have HIV, you likely will not obtain insurance coverage. However, the employer must pay you the amount of premiums paid for the other group members in the event that you are not eligible for coverage under a group plan with a small membership.

Some workplaces or sponsoring associations may offer flexible group insurance plans that allow members, at each member's own expense, to add higher or additional insurance to their basic benefits coverage. Opting for higher or additional coverage will usually require you to provide information about the condition of your health. If you are HIV-positive, you will have to disclose your HIV status in the application process, and you will in all likelihood not qualify for the extra coverage.

3.1.2 Individual Insurance Plans

Individual insurance plans are private policies you purchase for yourself and your family members. These plans can be purchased from a broker, insurance agent or insurance company. Self-employed, contract and seasonal workers typically purchase their own private insurance plans. In addition, individuals who are not employed or who are not eligible for an employee sponsored group insurance plan, and individuals who are eligible for a group plan but wish to have higher coverage than that provided by their group plan, may sometimes purchase individual insurance policies. The cost of purchasing a private insurance policy will depend on the type and amount of insurance you want, as well as other factors including your health status and age at the time of purchase. Unlike most group insurance plans, individual insurance plans require you to provide evidence of good health and this will include disclosing your HIV status or submitting to an HIV antibody test. If you are HIV-positive, you cannot obtain individual insurance coverage unless you purchased an individual plan prior to becoming HIV-positive. This is true even if you are free of symptoms.

3.1.3 Government Insurance Plans

The federal and provincial governments sponsor various basic insurance plans for residents of Canada. The Ontario government provides health insurance to all provincial residents, which covers visits to your personal care physician, some hospital services and medications you need during a hospital admission. Both the provincial and federal governments provide some disability and extended health insurance benefits, but these benefits have strict eligibility requirements and often require evidence of contributions and/or financial need.

3.2 Your "benefits booklet": get it, keep it

The "benefits booklet" is your key to information about what you are entitled to from your insurance company. You should receive a copy of this booklet when you become entitled to benefits at work. If you have a private plan, you should have received documentation about your plan. Always make sure that you have a copy of your booklet available to you. It is also very important to make sure that you have an up-to-date copy of your booklet. Benefits plans can change from time to time. Speak with your plan or benefit administrator or the human resources department to ensure that you have the most recent version.

3.2.1 Employee Benefits Booklet (Group Insurance Plans)

After you have served your eligibility or waiting period at the beginning of your employment, your employer or union representative should give you a benefits booklet that sets out the most important features of your insurance coverage. The booklet will likely include information on type and amount of benefits, claim procedures, covered expenses, eligible dependants, and exclusions. If you do not receive a benefits booklet you should contact the individual in your workplace responsible for managing group benefits. This may be your office manager, human resources specialist, plan administrator or union representative. Benefit booklets are required by law to be accurate; however, they are really just a summary of the group insurance policy. You will need to review the complete group insurance policy to determine the full scope of your coverage. The complete policy, or parts of the policy, can be obtained by contacting the insurance

company that issues the group plan to your union or employer.

3.2.2 Individual Insurance Policies

You usually get a copy of your individual private plan when you purchase it from your broker or the insurance company. If you don't have a copy, or can't find yours, copies of your individual insurance policies can usually be obtained by contacting your broker or insurance agent and/or by contacting your insurance company.

3.2.3 Government Plans

In order to learn about your government insurance plan contact the government office that administers the plan, such as Human Resources and Skills Development Canada, the Ontario Ministry of Health and Long-Term Care and/or the Ontario Ministry of Community and Social Services. The Federal government also maintains a comprehensive listing of provincial and federal government benefits online at www.canadabenefits.gc.ca

3.3 Confidentiality

In order to maintain your privacy, when requesting information about your insurance coverage, you may wish to say that you need the information for tax or financial planning purposes. Or you can say that you require a complete picture of your insurance coverage as your spouse or partner is in the process of purchasing additional insurance.

3.4 Storing Your Documents

Once you have reviewed your benefits booklet and/or insurance policies, you should make a photocopy of the booklet and/or the

policy and store it with your financial papers. It is a good idea to include with the photocopy the contact information for your insurance agent or insurance broker. In the alternative, you may wish to store a photocopy of your insurance policy and contact information in your safety deposit box. Let your beneficiaries know where you keep your documents, and consider giving them each a copy of the benefits booklet and/or insurance policy. It is also important to keep this information up-to-date. If you are issued a new booklet, make sure that you note which plan is current. If you have provided copies to your beneficiaries or powers of attorney, make sure that they too have copies of the most current information.

3.5 The difficulties in getting the contract and what you can do about it

Some individuals experience great difficulty obtaining information about their group insurance plans and/or private insurance coverage. This can occur for a variety of reasons, not the least of which is that the insurance industry and insurance providers benefit by keeping insured persons in the dark as they are less likely to make claims and less likely to appeal when their claims are denied.

If you are experiencing difficulty obtaining information about your insurance plan, contact the Consumer Assistance Centre which is a non-profit, non-sales help-line in French and English that is operated by the Canadian Life and Health Insurance Association (CLHIA). The Consumer Assistance Centre can assist you in getting a copy of your employee benefits booklet or individual insurance policies. The Consumer Assistance Centre can also assist you in locating misplaced insurance documents.

You can call the Consumer Assistance Centre free of charge: 1-800-268-8099 or (416) 777-2344 in Toronto. Or write to :

Consumer Assistance Centre
Canadian Life and Health Insurance
Association Inc.
1 Queen Street East, Suite 1700
Toronto, Ontario M5C 2X9
www.clhia.ca

If after calling the Consumer Assistance Centre you still are unable to obtain your employee benefits booklet or insurance policy, contact your local HIV/AIDS organization, community legal clinic or consult a lawyer.

4. Disability Insurance

Disability insurance is designed to replace lost income if you become disabled and unable to earn enough income to meet your financial obligations. Short-term disability plans provide benefits for a short period of time, usually between four and six months, to a person who is temporarily disabled and who expects to return to full-time employment. Most short-term disability benefits are paid weekly. Long-term disability plans provide benefits if you become permanently disabled. They have an elimination or qualifying period and benefits are typically paid monthly. To qualify for either short-term or long-term disability benefits you must meet the definition of “totally disabled” as set out in your insurance policy. The definition of “totally disabled” varies widely from plan to plan and may even change within a single plan after the initial phase of disability. It is very important, therefore, that you carefully read the definitions section of your disability insurance policy.

Disability insurance under a group insurance plan is often available to employees or other group members without having to provide

evidence of good health. Individual disability plans are also available; however you will usually be required to submit to a medical examination or HIV test before being issued an individual policy. Individual disability insurance is not available for uninsured persons living with HIV/AIDS.

If you are an insured person who has been diagnosed with HIV, you must meet the definition of disability as set out in your policy before you can collect either disability benefits under your group insurance plan and/or individual insurance. Your disability claim will not be approved on the basis of a positive HIV test alone.

4.1 Short-Term Disability

Short-term disability (STD) benefits pay a portion of your salary if you need to take a brief medical leave from work. The benefits usually amount to 50, 60 or 66 2/3 percent of your salary for a period of 13 to 26 weeks. Your employer holds your position for you during your medical leave, as short-term disability benefits are only available for individuals who are expecting to return to the workforce.

Short-term disability insurance is usually provided as part of your employee benefits group plan at work. Increasingly, however, employee benefit plans use the Federal government's Employment Insurance sickness benefits to supplement or in place of short-term disability benefits. The employer usually pays the premiums in full; however, sometimes the premiums must be paid, in part, by the employee. Typically, short-term disability benefits are provided to all employees without the requirement that they take a medical exam to prove insurability. This may not be true if you are a member of a small workplace (fewer than 25 employees).

Be sure to consult your doctor before you complete an application for short-term disability. Your doctor must support your decision and must be comfortable providing medical evidence in support of your application. If your doctor cannot provide specific and detailed information about your health condition, your application may be denied and/or delayed.

Once you have spoken with your doctor and have decided to take some time off work, you will have to notify your employer, and provide them with a letter from your physician stating that you are ill. You must then ask your Human Resources department for a short-term disability application. You do not have to reveal your HIV status to anyone in your place of employment; however, your doctor may have to reveal your condition to your insurer.

You generally start receiving money from your short-term disability policy within one to fourteen days after submitting your medical evidence and completing an application. However, there may be additional restrictions which will affect when your short-term disability benefits begin. You will have to review your employee benefits booklet to learn about any restrictions. There may be a term in the group policy which requires you to use all of your sick days and vacation days before receiving short-term disability money. Or, you may be required to apply for, and exhaust, Employment Insurance sickness benefits.

Individuals not covered under group insurance plans may be able to purchase private short-term disability policies on a limited basis. However, private disability policies are very expensive and they are not a good option if you have significant savings, or if you can borrow enough money from your family or friends to get you through short periods of illness or disability. In addition, like

most individual insurance plans, private short-term disability policies are unavailable to individuals who have HIV/AIDS.

4.1.1 The role of EI Sick benefits as STD Benefits

Some short-term disability plans require you to use all of your sickness benefits from Employment Insurance (EI) before becoming entitled to any money from short-term disability. Other short-term disability plans will cover you in place of Employment Insurance benefits. Read your policy carefully to determine how your short-term disability benefits interact with Employment Insurance. In any event, if you have bills to pay and you are waiting for your short-term disability benefits to be approved or kick in, you may have no other choice than to apply for Employment Insurance sickness benefits. Employment Insurance sickness benefits are also available to those who do not have short-term disability insurance through their workplace.

Employment Insurance is an insurance program sponsored by the federal government, and administered through Human Resources and Skills Development Canada. You may qualify for Employment Insurance sickness benefits if you can prove that you are unable to work because of ill health, and that you would otherwise be available for work. The basic benefit rate is 55% of your average income up to a maximum of \$413 per week. Provincial and federal taxes will be deducted from any benefits you receive from Employment Insurance. You can receive Employment Insurance Sickness Benefits for a maximum of 15 weeks. There is usually a two week waiting period before benefits can be paid (see section 4.1.2 for more information). Employment Insurance will not pay for your medications and many people who are on

Employment Insurance, but don't have drug coverage, apply for the Trillium Drug Program, which is explained below.

4.1.2 Eligibility Criteria for EI Sickness Benefits

You must prove that your regular weekly income has been decreased by more than 40% due to illness in order to be eligible for sickness benefits sponsored by Employment Insurance. You must also show that you have accumulated 600 insured hours in the last 52 weeks or since your last Employment Insurance claim.

To apply for sickness benefits you must complete an Employment Insurance application at your local Human Resources and Skills Development Canada office, or online at <http://www100.hrdc-drhc.gc.ca/ae-ei/dem-app/english/home2.html> You should apply for Employment Insurance sickness benefits as soon as you stop working, even if you receive or will receive money through a group or individual short-term disability policy. Any delay in filing your claim for EI sickness benefits may cause a loss of benefits. You will be required to submit your last Record of Employment with your application for Employment Insurance. Your employer is required to give you your Record of Employment within 5 days after leaving work. If you do not have a Record of Employment, submit your application and enclose a pay stub or cheque and/or work schedule as proof of your employment. If getting your Record of Employment is a problem contact your local Human Resources and Skills Development Canada office for assistance.

In addition to your Record of Employment you will require your social insurance number, driver's license or birth certificate, banking information, details regarding your most recent employment including your gross salary

and a medical certificate completed by your doctor indicating how long your illness is expected to last. You will not be reimbursed for any fees requested by your doctor for preparing the medical certificate.

Once you are found eligible for Employment Insurance sickness benefits, you will have to serve a two-week waiting period before your sickness benefits begin to be paid. This period is the first 2 weeks of your claim. You only have to serve this 2-week waiting period once, which means if you reopen a claim for benefits you do not serve another 2-week waiting period in relation to that claim. The waiting period may be waived or deferred if you are receiving sick leave pay from your employer or short-term disability benefits under a group insurance plan.

You must regularly submit a claimant's report while receiving sickness benefits. And you must report any earnings you make in your report. If you work while on EI, your earnings will be deducted dollar for dollar from your sickness benefits. And any benefits you receive from a group insurance plan for loss of income will be deducted dollar for dollar from your sickness benefits. If you are covered by a group insurance plan and choose not to apply for the income loss payments, any income loss payments to which you would be entitled, had you applied for them, are still determined to be earnings and will be deducted dollar for dollar. Any monies you receive from a private insurance disability plan will not affect your claim. Disability benefits from Canada Pension Plan will not affect your claim.

If you require assistance with your Employment Insurance sickness benefits application, you should contact your local Human Resources and Skills Development Canada office. If you disagree with any decision made by an Employment Insurance representative or agent you can appeal that decision and should immediately contact your

local community legal clinic or local HIV/AIDS organization.

4.1.3 EI sickness benefits: Problems to Watch Out For

The most common problem to watch out for when accessing EI Sick occurs when the EI sick benefits are ending. A last payment notice will be sent to you when you have received all the EI sickness benefits to which you are entitled (up to a maximum of 15 weeks). If you are feeling healthy then you may return to your work. If you no longer have a job, you may be able to receive regular Employment Insurance benefits without a waiting period. You may receive up to 50 weeks when regular Employment Insurance benefits are combined with sickness benefits. In order to receive EI regular benefits, you must be looking for a job, and you must state that you are "ready, willing and able to work" at all times.

If you are not well enough to return to work, then you will have to look for other benefits or pensions that you might be eligible for because of your disability: for example, a group long-term disability benefit, or a Canada Pension Plan disability benefit. If you do plan to apply for either of these benefits, then you should **not** also apply for EI regular benefits after your EI sickness benefits have run out. Because you have to state to the Employment Insurance Commission that you are "ready, willing and able to work", you may contradict other statements in your applications for disability benefits that you are "totally disabled and unable to work". You might end up endangering your entitlement to all of these benefits because of the contradictory statements.

4.1.4 Application Process

The application process for short-term disability (STD) will vary depending on what type of STD is available and who administers the plan. Some large companies have their own short-term disability programs, and some use insurance companies to provide short-term disability.

Usually, you will need to request forms which have to be completed by your physician indicating that you are not able to work, and providing some indication of when you are likely to be able to return to work. In the case of insurance company-based short-term disability plans, these are then submitted to the insurance company for a decision about eligibility.

If the STD plan available to you is in fact EI sickness benefits, then you will need to undergo that process. As indicated above, you can apply for EI sickness benefits online at www100.hrdc-drhc.gc.ca/ae-ei/dem-app/english/home2.html or at the local Human Resources Centre of Canada. You can find a listing of these centres by visiting www.hrsdc.gc.ca/en/gateways/where_you_live/regions/offices/on.shtml or by calling 1 (800) 206-7218. When you apply for these benefits, it can definitely speed up the process if you have a record of employment issued by your employer which indicates that you've had to leave work due to illness (code "D" on the form).

4.2 Long-Term Disability

Long-term disability (LTD) benefits pay a portion of your salary if you become severely ill or disabled and do not expect to return to your job because of the disability. Just like short-term disability benefits, long-term disability benefits are usually provided under group insurance plans sponsored by unions or employers. Not all employees have a long-

term disability benefit as part of their group benefits plan however; once again, you should read your benefits booklet carefully to see exactly what kind of coverage you have. Typically, long-term disability benefits start between 6 months and 12 months after you have left work due to ill health. And long-term disability benefits usually replace anywhere between 50% and 90% of your salary.

Most long-term disability plans require you to use up any short-term disability or Employment Insurance sickness benefits before you can qualify. In addition, you will be required to apply for any other sources of income for which you may be eligible, including Canada Pension Plan disability benefits. And if you become eligible for Canada Pension Plan disability benefits, any monies you receive from the Canada Pension Plan will be deducted dollar for dollar from your long-term disability benefit. Long-term disability benefits are taxable by both the federal and provincial government, but only if your employer paid the premiums for your long-term disability benefits while you were still employed. If you paid these premiums yourself while you were employed, then you will receive the long-term disability benefit tax-free.

4.2.1 Eligibility

To be eligible for long-term disability insurance, you will have to complete an extensive application and your physician(s) will have to submit a detailed medical report. You are not required to disclose your HIV status to your employer; however, your physician will have to advise the insurance company of your status, if your status has any bearing on your inability to maintain employment. (see section [4.2.5.1](#) on Disclosure)

In order to be eligible for long-term benefits, you must meet the definition of “total disability” as set out in the group insurance plan or individual insurance plan under which you have coverage. The definition usually refers to the inability of an employee to fulfill the essential duties of their occupation. It is therefore important that you carefully read your policy and discuss the definition of long-term disability with your treating physician before you apply. It is often very helpful if you can provide your physician with a detailed job description and identify which parts of your job you have difficulty with because of your disability. You will not be deemed eligible for benefits based solely on a positive test for HIV, as it is recognized HIV does not, by itself, mean that an individual is unable to fulfill the duties of his or her employment. Your physician will be asked to provide your insurer with clinical evidence such as CD4-cell counts and viral loads, in addition to evidence of physical symptoms, such as depression, diarrhea, fatigue and any other symptoms that are seriously affecting your ability to work. You may also be asked by the insurance company to undergo a medical examination by an independent medical specialist to help determine whether you are eligible for benefits.

4.2.2 Pre-Existing Conditions (HIV as a pre-existing condition)

Most long-term disability insurance plans have a pre-existing condition clause which excludes coverage for claims arising from medical conditions that existed immediately prior to the insurance policy becoming effective. This means that individuals who were HIV-positive prior to obtaining insurance either privately or through a group plan may be denied benefits for conditions arising from their HIV status; depending on how long after they obtain the insurance they become totally disabled due to their HIV status.

For individually-purchased, private insurance plans, your pre-existing HIV infection will probably mean the insurer would already have refused to issue you any long-term disability insurance in the first place. For group insurance plans through your workplace, however, the insurer probably did not know you were HIV-positive when you obtained the insurance through the group plan. However, simply being HIV-positive when you became eligible for a group insurance plan does not mean that you will not be able to get long-term disability benefits from that plan. Each policy will define the pre-existing condition exclusion differently, so you should read your policy carefully to see if it applies in your circumstances. However, each policy usually looks at two different time-periods, the period immediately before the insurance becomes effective, and the period after you become insured.

4.2.2.1 Effective Date of Insurance

The first thing is to determine when you were first covered under the policy. For most people, the date that coverage commences, or the “effective date of insurance” is about 3 months or 90 days after you start working. After 90 days, your employer should make sure that you are signed up to receive benefits under the group plan. You will be eligible to make insurance claims for all your benefits: health, dental, etc. You will also be eligible to claim long-term disability insurance if you become disabled, unless there was a pre-existing condition during a defined “pre-insurance eligibility period”.

4.2.2.2 Pre-Insurance Eligibility Periods

Your pre-existing condition will only affect your eligibility to claim a long-term disability benefit if you suffered symptoms, consulted a doctor, or took prescribed medications, during a defined period before your effective

date of insurance. For example, many plans say that if you consulted a physician or took medications for a pre-existing condition in the 3 months before your insurance becomes effective, then you will not be allowed to make a claim if you become disabled because of that condition within a year after the insurance become effective (see next paragraph). That means that if you are HIV-positive, but you are otherwise healthy, are not on medications, and have not consulted your doctor about your HIV status for a long-enough period before your insurance becomes effective, then you will not be excluded from making a claim for long-term disability benefits because of your HIV status later on.

4.2.2.3 Post-Insurance Exclusion Periods

If you had consulted your physician or were taking prescribed medications during the pre-insurance eligibility period, group insurance plans will then look to a post-insurance exclusion period, which excludes coverage for claims made by an employee within usually one, sometimes two years after their insurance becomes effective (the time period will depend on the policy, and be set out in the benefits booklet). This means that individuals who were being treated for their HIV infection immediately prior to commencing work and being enrolled in a group insurance plan may not be able to make a claim for disability benefits within the first one or two years of their employment if they become seriously ill. After that exclusion period is over, those individuals will be able to make a claim for long-term disability benefits the same as anyone else, even if their disability at that time is caused by their HIV infection.

People with HIV/AIDS will often work through the post-insurance exclusion period, even if they are seriously ill, so that they can collect benefits at the end of one or two years (the length of this period depends on the wording in each policy). It is important to

remember, however, that if you are unable to work because of a condition unrelated to your HIV status, then you should still be eligible to claim long-term disability benefits even during the exclusion period, as the pre-existing condition exclusion should not apply to you. In any case, if you are having problems with your insurance company acknowledging your eligibility to make a claim for long-term disability benefits, you may have to hire a lawyer to commence legal proceedings against the insurer.

4.2.3 Elimination periods

Most insurance plans contain an elimination period, which provides for a specified period of time during which an insured person must be disabled before they are eligible for income replacement insurance benefits. The elimination period in individual insurance plans is often 90 days. This means that you have to be disabled for 90-days before receiving any money from the insurance policy. You can purchase a plan with a shorter elimination period such as 60 or 30 days; however it will be more expensive. You do not have to wait until the end of the elimination period before you file your claim for benefits. If you do wait there will likely be a further delay in processing your claim.

It is important to check your insurance policy to determine if your elimination period requires consecutive days of disability or is satisfied with a “residual” disability. In the case of a 90-day elimination period, “consecutive days of disability” means that you have to be disabled for 90-days in a row in order to satisfy the elimination period. If your plan allows for a “residual” disability, your days of disability do not have to follow one after the other; they just have to add up to 90-days.

In addition, it is important to check your policy to determine if it contains a recurrent disability provision. A recurrent disability provision in your policy means that you do not have to go through more than one elimination period during a specified period of time. For example, a five-year recurrent disability provision in your policy means that you only have to satisfy one elimination period in five years. This is relevant if you are sometimes able to return to work on a temporary or permanent basis, but then become totally disabled again within a certain time period: in those circumstances, you do not have to go through the whole process of applying for long-term disability benefits again, and you do not have to wait through an elimination period before you can receive benefits.

Finally, it is very important to check your benefits booklet to find out whether there is a requirement that you be “actively at work” when you first become disabled. This is especially important in cases where there the employment may be about to be terminated, but you want to access LTD benefits before you cease to be an employee. Some plans will deny your benefits if you are not actively at work when you became disabled.

4.2.4 Definitions of disability (own occupation vs. any occupation)

The most important provision in your insurance plan is the provision that defines total disability. You must satisfy the definition of total disability in order to be eligible for long-term disability income replacement benefits. Read the definition carefully to determine the test you must meet. In addition, pay careful attention to the time period to which the definition of total disability applies. Often, insurance policies will state that you must meet one definition of disability during the first two years of your claim, and a second

substantially different definition after that time. The two most common definitions of disability are ‘own occupation’ disability and ‘any occupation’ disability. These are commonly referred to as “own-oc” and “any-oc”.

4.2.4.1 Own Occupation Disability Insurance

Own occupation disability insurance defines a total disability as a serious illness or injury that prevents you from being able to work at, or perform the substantial duties of your own occupation, or the job you left immediately before becoming totally disabled. If your policy contains an ‘own occupation’ definition you might be able to collect long-term disability benefits and work at the same time, as long as the work you are undertaking is not that of your own occupation (subject to any limits on the maximum amount of employment income you can earn before your earnings are subtracted from your monthly disability benefit). Own occupation LTD benefits usually last for a period of about 2 years, after which eligibility for ongoing LTD switches to an any occupation definition.

4.2.4.2 Any Occupation Disability Insurance

Any occupation disability insurance defines a total disability as a serious illness or injury that prevents you from being able to work at any employment compatible with your education, training, and experience. This definition of total disability is much broader than that of the ‘own occupation’ definition and simply means that if you are able to work at a job compatible with your skill set you will not be eligible for long-term disability benefits. This definition often kicks in after you have already been receiving long-term disability benefits for some time under the own-occupation definition, usually after two years.

4.2.5 Application Process

Each insurance company has its own application procedure so speak with your employee benefits representative or insurance agent about the application process that applies to you. Normally the application process involves securing the necessary forms from either your employer or the insurance company. Many people make their applications for LTD prior to the end of the elimination period, particularly if it is clear that they will not be well enough to return to work when their STD or EI sickness benefits end. The forms will require specific medical information, to be provided by your physician.

4.2.5.1 Disclosure and applying directly to insurer

You have no obligation to advise your employer, supervisor or any of your co-workers of your HIV status. However, you will likely have to disclose your HIV status on your long-term disability application and when asked on the application you should be completely honest about your health. If your disability is HIV-related, then your physician(s) will also have to provide specific medication information relating to your diagnosis and your prognosis.

When you submit an insurance claim, the claim will likely pass through the hands of your office administrator, employee benefits specialist or human resources representative at work before it is sent to the insurer. In order to prevent any individual in your workplace from reviewing the details of your claim, you may wish to submit your claim directly to your benefits administrator in a sealed envelope. When you submit your claim, you may also want to inform your benefits administrator that you wish the envelope to

remain sealed and that the claim should be sent immediately to your group insurer.

In the alternative, you may wish to contact the customer service department of the insurance company that issues your group plan and advise them that you wish to submit a claim without the intervention of your employer. You may request that the insurance company accept receipt of the claim directly. Or you may ask if there are any other claims procedures that the insurance company has to protect your confidentiality in the workplace. Be prepared, however, as the insurance company may refuse to accept the claim and may tell you to deal with your employer. If this occurs and you have little faith in your employer to protect the information contained in your claim, you should contact the Customer Assistance Centre of the Canadian Life and Health Insurance Association at: 1-800-268-8099 or 416-777-2344 in Toronto.

All insurance companies have strict policies regarding the confidentiality of client information and are required by law to keep claims information private. This does not mean that only one person in an insurance company will know about your claim and medical condition; in fact, your information may be shared and discussed amongst several different people working for an insurance company. What it does mean is that the insurance company must have your written consent to discuss your medical condition with any person who works outside of the insurance company.

4.2.5.2 Medical reports – who pays for them?

When applying for long-term disability benefits you will have to submit a detailed medical report. The medical report form will usually be provided by the insurance company. You will likely be asked by your

physician or specialist to pay a significant sum of money for the preparation of the report.

Your insurer should cover the cost of this medical report, unless your long-term disability policy clearly states that you are liable for the cost. Therefore, read your insurance policy carefully and if you have any questions speak with your insurance agent or your employee benefits representative at work. If you cannot find any reference to the issue of who has to cover the cost of medicals in your insurance policy and your agent advises you that you are responsible for the cost, ask your agent under what authority he or she is making that decision. If the agent refers you to a company policy or company directive ask him or her to send you a copy to review. Be assertive with your insurance company representative and insist that the insurance company pay, unless your policy specifically states otherwise. If they refuse, make sure you keep a written record of the name of the individual(s) you spoke to, the documents they relied on, the amount you paid for the report and the important dates. It is a good idea to ask the insurance company to put their decisions in writing and send them to you. This information may assist you if you have to bring a legal action against your insurer at a later date.

4.3 Staying on benefits after you've been accepted

For many PHAs one of the most significant problems experienced in relation to long-term disability is how to maintain the benefits. Insurance companies have a financial incentive to move you off of benefits and back into the workforce as soon as they can because of the cost involved in paying out benefits to you. Many individuals will face their first hurdle with LTD eligibility when they reach the transition from the "own-occupation" to "any-occupation" definitions

of total disability, usually after about two years of being on LTD. Other problems come up when individuals have been receiving LTD benefits for a number of years. Often at this point, insurance companies will use a number of methods to determine whether rehabilitation and re-training might be suitable to help you move off of benefits and back to work. It can often feel like they're trying to kick you off benefits and sometimes feels like harassment. For those who are thinking about returning to work, however, this process can sometimes create opportunities to access a number of expensive resources through the insurance company as you transition back to employment.

4.3.1 Medical updates (and who pays for them)

Even after you are awarded long-term disability benefits, you may be required to submit medical information on a regular basis. The medical information required may take the form of verbal and/or written reports depending upon the demands of your insurance company. Some insurance companies can be very aggressive and will require written reports from your general physician and specialists on a monthly basis. Other insurers may leave you alone for an extended period of time and or ask you to have your doctor contact them by telephone when your situation changes. The frequency of these requests depends a lot upon the personal circumstances and medical condition of individual claimants. Your insurance company should cover the cost of obtaining any medical reports unless your insurance policy states otherwise.

4.3.2 Return to Work programs

Insurance companies would obviously prefer that insured individuals return back to work

after a period of serious illness, rather than the insurer having to continue to pay them money. Therefore, many long-term disability policies have a clause that strongly encourages, and often requires disabled individuals to attempt to return to work, either gradually, part-time and/or on light duties. The insurance company then deducts a percentage of the income the insured individual earns during the return to work program from his or her long-term disability benefits while guaranteeing a minimum income during the return to work program.

Often this process is begun with the involvement of a rehabilitation consultant, usually hired by the insurance company. They will usually arrange for someone to visit you and undertake an assessment of your disability and your current abilities. The consultant will then usually submit a report with recommendations to the insurance company regarding your current health and their opinion about whether you have a capacity to return to work. This may include recommendations about specific kinds of training, physical therapy or types of work that you can do. You should get a copy of the report they produce. If you don't, you should request a copy from your insurance company.

You should insist on the close involvement of your primary health care provider if your insurance company requires you to attempt some form of modified return to work. Most return to work plans have a trial period, i.e. 12 months, during which time you should be able to go back to full disability benefits if you are unable due to your illness to manage the modified work. Unfortunately, in many cases, insurance companies have suspended or refused to reinstate full benefits for individuals who report that they are unable to comply or continue with their return to work program due to ill health. If this happens, the insured individual should immediately contact a lawyer.

4.3.3 Am I still an employee?

When you are receiving long-term disability benefits, you are still considered an employee of your business or company. And even though you are not working you may be eligible for some of the extended health benefits and life insurance contained in the group insurance plan offered by your workplace. This will depend on each group insurance plan, so you should review the plan carefully to see whether or not you are still eligible for extended health benefits while you are off work because of your disability. For more information about eligibility for extended health benefits, see [Section 5](#).

4.3.4 Can I be fired while on LTD?

As a general rule an employee cannot be fired while they are disabled and in receipt of long-term disability benefits, especially in the short term. However, when an employee is away from work for a significant period of time, i.e., more than 2 years, an employer may fire the employee and argue frustration of the employment contract. If this situation arises, you should immediately contact a lawyer.

Even if you do lose your job while you are on LTD benefits, this will not mean that you will lose your long-term disability coverage. The only way that your long-term disability coverage will end is if your insurer determines that you are no longer totally disabled within the meaning of the insurance policy.

4.4 Interaction with other sources of income

Some people who receive income replacement benefits under a long-term disability policy also receive money from other sources, like casual or part-time or self-employment (if you are receiving benefits under an 'own occupation' definition of total disability) or

government insurance benefits like the Canada Pension Plan and/or Ontario Disability Support Program. If you are on long-term disability and you have additional sources of income, your additional income will likely affect the amount of long-term disability benefits you receive. The amount of long-term disability benefits you receive will also be affected by any benefits that you are eligible for but for which you have failed, or have refused, to apply.

Check your insurance policy to see if it has a clause that sets a limit on the amount of income you can receive while disabled from all sources. Most plans contain a limit on the amount you can receive, and this amount is based on your pre-disability income. For example, if the limit from all sources is 90% of your pre-disability earnings and you are making 10% of your pre-disability earnings through self-employment, you will only receive disability benefits from your long-term insurance plan equal to 80% of your pre-disability earnings. This calculation can become very complex, so if you have multiple sources of income you should speak with your insurance company.

4.4.1 Canada Pension Plan Disability Benefits

The Canada Pension Plan (CPP) is a government insurance plan that issues a monthly income benefit to individuals under the age of 65 years who have contributed to the Canada Pension Plan and who have a disability that is “severe and prolonged”. “Severe” means your condition prevents you from working regularly at any job, and “prolonged” means your condition is long term or may result in your death. If you became disabled after December 31, 1997, you must have contributed to the Canada Pension Plan in four of the last six years. During that period, you must have earned at least 10 percent of each Year’s Maximum

Pensionable Earnings (YMPE). The YMPE amount changes from year to year and can be obtained by calling Human Resources and Skills Development Canada. For 2004, the YMPE is \$40,500.

Group and individual insurance plans often require insured individuals to apply for Canada Pension Plan Disability (CPP-D) benefits if you are also applying for long-term disability benefits under the plan. You should read your policy to determine if you are obliged to apply. Your policy may contain a clause that allows your private or group insurer to deduct any Canada Pension Plan disability payments you are entitled to under the Plan if you fail to apply. Even if your policy does not contain such a clause, it is in your best interest to apply for CPP-D benefits. This is because, if you are found eligible for a CPP-D benefit, CPP will not include periods when you have no earnings due to disability when calculating your retirement benefits. That means that being disabled will not have an adverse effect on your retirement pension benefits.

You must apply for a CPP-D benefit in writing. For an application kit, contact Human Resources and Skills Development Canada at 1-800-277-9914. The application kit contains all the information you will need to apply and includes an application form, personal questionnaire, medical report to be filled out by your primary physician, and a consent to release of information form. The Canada Pension Plan cannot pay a disability benefit unless the application is received before the disabled individual dies. However, surviving spouses or common law or same-sex partners may be eligible for Canada Pension Plan survivor benefits.

The Canada Pension Plan disability benefit is made up of a flat-rate amount and a variable amount that is based on your history of contributions. The Canada Pension Plan also

provides a monthly benefit for the dependent children of a disabled person. The Canada Pension Plan does not pay for medications or transportation for persons with disabilities. There is a maximum amount that can be paid as disability benefits under the Canada Pension Plan. As of January 2004 the maximum was \$992.80 per month. A dependent child's benefit is \$192.68 per month, per child. The Canada Pension Plan disability payment is taxable income; however, tax is not deducted from the benefit unless requested by the disabled individual. If you do not request tax to be deducted from your monthly payments, you may be surprised at the amount of money you owe as income tax at the end of the year, and you may have difficulty paying this amount, so you should consider requesting that tax be deducted at source.

If you are found eligible for a Canada Pension Plan disability benefit your payments will start four months after the date the Canada Pension Plan finds you to be disabled. You may be entitled to a retroactive payment depending on the onset date of your disability; however, your disability benefits will begin no earlier than twelve months before the date you applied. The disability payment can be deposited directly into your bank account or sent to you by cheque and this is usually done within the last three business days of each month.

After you start receiving your benefit, the Canada Pension Plan may ask you to provide medical evidence confirming that you remain unable to work. You have to inform the CPP if your medical condition changes significantly or if you do return to work. If you wish to attempt a gradual return to work, the Canada Pension Plan offers several programs and financial incentives that may be of assistance to you. If you return to work but find you are unable to continue working due to your illness, your Canada Pension Plan benefits can be reinstated. If it has been less than five

years since you went off of CPP-D benefits, and you have reapplied within six months of leaving work due to the same illness, you should be eligible for rapid reinstatement. You should contact Human Resources and Skills Development Canada at 1-800-277-9914 as soon as possible and request a rapid reinstatement application.

If you do not have private or group insurance benefits you can apply for social assistance (Ontario Works) while waiting for your Canada Pension Plan disability benefits application to be processed. If you are found eligible for Canada Pension Plan benefits you will have to inform Ontario Works and some or all of the money you received from Ontario Works may have to be repaid (depending on whether you receive a retroactive payment of benefits from CPP).

If you are already receiving long-term disability benefits from your private or group insurance plan, and your application for a Canada Pension Plan disability benefit is accepted with a retroactive amount payable to you, you will probably also have to pay back to your insurer a portion of the LTD benefits they paid to you for the same period that the retroactive payment from CPP is covering. Your insurer may insist that you sign a form allowing CPP to pay that money directly to the insurer.

You will be advised in writing by Human Resources and Skills Development Canada if you are not eligible for disability benefits from the Canada Pension Plan. If you wish to appeal a denial of benefits, you have to send a letter to Human Resources and Skills Development Canada asking them to reconsider their decision within 90 days of receiving the denial. If your reconsideration results in a second denial, you may appeal to the Review Tribunal within 90 days of receiving that denial. If you are denied by the Review Tribunal, you may request that your

appeal be heard by the Pension Appeals Board. You can contact your local community legal clinic for assistance with your reconsideration request and appeal before the Review Tribunal or Pension Appeals Board.

4.4.2 Ontario Disability Support Program

The Ontario Disability Support Program (ODSP) is a government insurance plan that issues a monthly income benefit to individuals who meet their definition of disability and are also in financial need. ODSP also provides some prescription drug, dental and optical coverage. To be eligible you must qualify financially (i.e. have income and assets below a certain level) and have a substantial physical or mental impairment that is continuous or recurrent and is expected to last one year or more. Many people apply for both CPP-D and ODSP benefits at the same time as they may be eligible to receive some income support from both sources. Any money you receive from CPP disability benefits will be deducted dollar for dollar from your ODSP entitlement. Even if you are in receipt of CPP disability benefits you should consider applying as well for ODSP because you may be able to get a drug card to cover the cost of your prescription medications. ODSP is considered a “payer of last resort”. This means that they will require that you try to access any other sources of income for which you might be eligible, including CPP disability, private insurance and Employment Insurance benefits.

In order to apply for benefits you should contact your local Ontario Disability Support Program office. The office will arrange an appointment to meet with you to talk about your financial circumstances. In order to qualify financially you must have under \$5,000 (if you are single) and under \$7,500 (if you have a spouse, common law or same sex

partner) in cash, RRSPs, or other forms of assets. Some assets are not counted, like your home if it is your principal residence, your car, and most life insurance policies. If you qualify financially, you will be provided with an application package that you must fill in and submit within 90 days of receipt of the package.

According to a recent policy announcement from the Ontario Disability Support Program, any applicant who has tested positive for HIV will meet the eligibility requirement of having a substantial physical impairment. Therefore, if you meet the financial requirements and you have tested positive for HIV, your application for Ontario Disability benefits should be approved.

It usually takes in excess of six months for your application to be processed ODSP and for you to receive your first payment. You can apply for social assistance (Ontario Works) while waiting for your Ontario Disability Support Program application to be processed. If you are found eligible for Ontario Disability benefits, the amount of money you will get will depend on the size of your family and the amount you pay each month for housing. The maximum amount for a single person is \$930 per month. The maximum amount for a family of two is \$1417 per month.

ODSP also offers the Employment Supports program to assist people with disabilities to return to work. You do not have to be receiving Ontario Disability Support Program income support benefits to qualify for Employment Supports. You may qualify if you have a physical or mental disability that is expected to last a year or more and your disability makes it hard for you to find or keep a job. You may also qualify if you are working but are having difficulty keeping your job because of your disability. You may not qualify for Employment Supports if you are receiving disability benefits from other sources.

Employment Supports can assist you with a variety of things that you require to help you to find or stay at a job, like technical aids ranging from mobility devices to reading aids to adapted computers, job coaching and transportation assistance while you are searching or training for a new job. It is important to note that Employment Supports is also a “payer of last resort” so they will require that you exhaust any other sources of support to assist you in returning to work, such as programs through Employment Insurance, Canada Pension Plan, or private insurance like LTD. Contact your local Ontario Disability Support Program office for more information about Employment Supports.

It is possible to work while in receipt of ODSP benefits. If you are a single person and receiving monthly income support from ODSP you can earn up to \$160 a month at a job and keep your entire benefit cheque through the STEP Program. A family can earn up to \$235 a month at a job and keep their full benefit cheque. Seventy-five percent of all earnings above these amounts is deducted from the benefit cheque, dollar for dollar. If you find a full time job and are no longer financially eligible for income support, you still may be eligible to receive some drug, dental and optical benefits, especially if the cost of your medications is very high. If you find a full time job but are unable to continue to work due to serious illness, your full income support benefit should be reinstated quickly. If you are not reinstated, contact your local community legal clinic.

You will be advised in writing by the Disability Adjudication Unit of the Ontario Disability Support Program if you are not eligible for disability benefits. However, according to a recent policy change, any person who has tested positive for HIV will meet the disability requirement for ODSP.

If you wish to appeal a denial of benefits, or any decision made regarding your benefits by your local ODSP office, you have to send a letter to the Disability Adjudication Unit or to your local office asking them to conduct an internal review of their decision within 10 days of receiving the decision letter. If your internal review results in a second denial, you may appeal to the Social Benefits Tribunal within 30 days of receiving that denial. If you do not receive any response to your request for an internal review, you may appeal to the Social Benefits Tribunal within 40 days of sending your request. The Social Benefits Tribunal will not review your case unless you have requested an internal review. You should contact your local community legal clinic if you require assistance in appealing any decision of the Ontario Disability Support Program.

5. Extended Health Benefits (Sickness insurance)

Extended health insurance is a type of insurance that provides assistance with hospital and medical expenses not covered by the Ontario Health Insurance Program (OHIP) or other government programs. Most often, it includes coverage for prescription drugs and dental, and may include other services like massage or physiotherapy. You may have extended health insurance at work as part of your employee or union benefits package or you may purchase it through a group association plan or privately from an insurance agent or insurance broker. If you are HIV-positive you will not be able to purchase private extended health insurance although you may be eligible for the benefits under your group plan at work. In some cases, eligibility for extended health benefits requires that you be “actively at work” which means that eligibility ceases if

you should have to go on to short-term or long-term disability (see 5.2.5).

5.1 Deductibles, Co-insurance and Maximums

Most extended health insurance plans do not pay 100 percent of the hospital and medical services covered. You may have to pay a small amount of the cost of the service at the start of each plan year. This is called a deductible. Your deductible may be \$25 or \$50 for each insured person, i.e., your spouse or partner and/or dependent children. In the alternative, you may pay a family deductible in the range of \$75 or \$100. Many plans do not cover the prescription filling fee charged by pharmacies, so you may be required to pay a filling fee out of pocket which will not be reimbursed.

You should also review your plan to determine if it has a co-insurance provision. A co-insurance provision requires you to pay a percentage of the cost of the covered service in addition to paying your deductible. The coinsurance percentage may be 10% or 20% of the cost of the covered medical or hospital service, or it may be higher depending on the service. For many PHAs, the cost associated with even just 20% of their total prescription costs is often unmanageable. In these cases, you may be able to access the Trillium Drug Program for help with these costs. See section 5.2.6 for more details on the Trillium Drug Program.

In addition, check your plan carefully for maximums, which are limits on the dollar amount the insurance company will pay for specific services. For example, your maximum coverage for eyeglasses may be \$200 in every 24-month period. There may also be a maximum limit on the total dollar amount the insurance company will pay for all extended health care services or during a specified period of time or during the lifetime of the insured person.

5.2 Claims

You should speak with your insurance agent or employee benefits representative at work to find out the procedure for filing an extended health insurance benefit claim. You may have to pay the cost of the expense up front and submit your receipts with a claim form to your insurance company. Alternatively, you may be given an insurance card that will allow the health service provider to bill the insurance company electronically. It is important to ask if your claim must be submitted within a certain period of time. For example, you may only have 60 days to submit your claim after the completion of the service.

5.2.1 High-Cost Drugs

Extended health insurance plans typically cover the cost of medications, including expensive prescription drugs. However, all insurance plans can be tailored to reflect the wishes of the purchaser and it is becoming more common for employers to purchase extended health insurance for their workers that excludes coverage for certain high-cost drugs, or that limits the maximum coverage available for medications such that employees with high drug costs would not take long to hit the maximum coverage. If your extended health benefits coverage is limited or subject to a maximum and the costs of your prescribed medications, after you have exhausted your benefits, is still significantly high relative to your income, you may be eligible for the Trillium Drug Program to assist you in paying for your medications (see 5.2.6 for more information on Trillium).

In the alternative, some employers have chosen to stop offering extended health insurance as a benefit altogether to save on business costs. If you begin employment at a job that offers only limited extended health benefits, or none at all, there is not much you

can do unless you can negotiate better coverage as part of your offer of employment. However, if an employer changes their benefits coverage in the middle of your employment, and the change would seriously affect your ability to continue that employment in the face of high drug costs to you, you should immediately contact a lawyer to see what your options are.

It is common for individuals to be denied private, individual extended health benefits and dental benefits if they are HIV-positive. However, HIV-positive persons that are denied extended health benefits under a group insurance policy offered by your employer can only be denied coverage if there are fewer than 25 employees in the group. If that is the case, and the employee is denied coverage because they are HIV-positive, the employer must pay the employee the cost of the premiums that they would otherwise be paying to the insurance company on the employee's behalf.

If extended health care benefits are not available to an employee as part of a group plan, or if an employee is denied coverage in a group plan with a small group membership because they are too high a risk for the insurer, the employee may either be offered health care benefits in exchange for an increase in their premium cost, or the employer may offer to pay the Ontario Trillium program user-fee cost in lieu of paying extended health benefits. Speak with your employee benefits representative about the options available.

5.2.2 Dental Benefits

Coverage for dental services is usually contained in its own separate extended health insurance plan. Basic dental plans usually cover regular check-ups, cleaning, fillings and x-rays, as well as root canals, periodontal

cleanings and scaling. Optional coverage may include more serious restorative work, like bridgework, dentures and/or orthodontic services.

You should obtain an estimate from your dentist before you undergo major restorative work. This estimate should be submitted to your insurance company or employee benefit administrator. Once your insurer receives the estimate they will send you a written explanation that will set out how much your insurance company will pay for the restorative work and how much you will be responsible to pay. Once you receive this information you can speak with your spouse or partner about their insurance coverage and whether your benefits can be co-coordinated so that your share of the cost of the restorative work is covered by the plan owned by your spouse or partner.

5.2.3 Other Health Benefits

Besides coverage for prescription medications, your extended health insurance policy will also likely include the following benefits:

- semi-private or private hospital accommodation
- special nursing services
- ambulance services
- hospital and medical expenses incurred outside of Canada
- artificial limbs, prostheses and medical appliances
- wheelchairs and other durable equipment
- specified medical or paramedical services that fall outside government plans (e.g., services from chiropractors, physiotherapists, podiatrists, osteopaths and optometrists); and
- vision care (eyeglasses and contact lenses)

Extended health insurance coverage varies considerably from plan to plan so you should read your policy carefully to determine what medical services are covered.

5.2.4 Optional Health Benefits

You may wish to purchase extra health coverage in addition to your individual or group plan. Some of the options that may be available are set out below.

A critical illness plan will provide you with a one-time cash payment if you are diagnosed with a life threatening illness. The illnesses covered are listed in the plan and usually include cancer, heart disease requiring surgery, heart attack or stroke. Kidney failure, blindness, organ transplant, paraplegia, quadriplegia and /or dementia may also be covered. This money can be spent in anyway you choose.

A hospital cash plan or hospital indemnity insurance plan will pay you cash, usually up to \$100 a day, if you are required to remain in hospital. This money can be used for childcare expenses, to pay someone to look after your pet or personal items you may need in the hospital.

A long-term care insurance plan will cover your expenses if you need to stay in a nursing home or chronic care facility. It will also cover the cost of having someone provide you with care in your own home.

Accidental Death and Dismemberment (AD&D) insurance would pay a set amount of money if you were killed as a result of an accident, or if you suffered the loss of a limb. These policies are often optional in group insurance plans.

Before you purchase any extra coverage you should review your existing health benefit

policies, and those of your spouse, common law or same-sex partner, and consider your personal circumstances and needs. You may be eligible for coverage under your spouse's or partner's plan for some of the costs that your plan does not cover. If you have financial resources or extended family and/or social support you may not require extra health or long-term care insurance. In addition, these plans vary considerably as to maximums, deductibles and premiums as well as claims procedures. Speak with your insurance agent or employee benefits advisor for more information.

5.2.5 Can I lose my drug and dental benefits while on LTD?

Even though you are not working you may be eligible for some of the extended health benefits contained in the group insurance plan offered by your workplace. You should read your employee benefits booklet to determine if you can continue to make claims for extended health benefits. Employers will often cut employees off extended health coverage at some period of time after they have left work.

If this happens, you may wish to contact a lawyer to discuss whether the employer was authorized to cut you off extended health benefits. It may also be possible to negotiate with your employer so that you will continue to pay some or all of the premiums for the extended health benefits yourself while you are off on long-term disability in order to keep your coverage.

5.2.6 Trillium Drug Program

The Trillium Drug Program is an insurance plan administered by the provincial government that provides coverage for individuals who have extraordinary

prescription medication costs. You may be eligible for the Trillium Drug Program if you have partial drug coverage from a private or group insurance plan, or if you have no coverage at all. To qualify, you must have drug costs equal to a certain amount of your income. If you do, the Trillium Drug Program will cover you for the remainder of the cost of your drugs after you have paid this deductible amount. The deductible amount is usually paid in quarterly installments, meaning you'll pay ¼ of the deductible amount every three months. Persons who are receiving social assistance (Ontario Works) or provincial disability benefits (Ontario Disability Support Program) are not eligible for benefits under the Trillium Drug Program, as the cost for their medications are already covered under those other programs. The Trillium Drug Program covers only those medications listed in the Ontario Drug Benefits Formulary; however, there can be exceptions to this rule for individuals with special needs and whose physicians apply for special access to other medications.

Trillium Drug Program applications can be obtained from your physician or at your local pharmacy. You can apply at any time and it takes about 2 to 4 weeks, and sometimes longer, for your application to be processed. The Trillium Drug Program has a deductible in the amount of 4% of your net income each year that you must pay for medications before full coverage will start. After you have paid the deductible amount for your drugs, the Trillium Drug Program will cover the full cost of your medications until the next program year. If you have partial insurance coverage the Trillium Drug Program may help you your share of the drug costs, provided they are high enough to meet the eligibility amount. You can find detailed information about the Trillium Drug Program at www.health.gov.on.ca/english/public/pub/drugs/trillium.html.

6. Life Insurance

A life insurance plan allows for the guaranteed payment of monetary benefits, called a death benefit, upon the death of the insured, to whoever is named in the life insurance policy (the beneficiary).

There are two kinds of life insurance: permanent and term. Permanent life insurance is used to insure permanent needs for which you will require protection over your whole lifetime. An example of a permanent need is an income for a spouse or partner. Funeral expenses are also a permanent need. Temporary life insurance is used to insure temporary needs that may change over your lifetime. They usually cover a specific period of time after which they expire. This means that the death benefit will only be paid if you die before the end of the period set out in the term policy. A mortgage is an example of a temporary need. Mortgage insurance would be term insurance which would cover the cost of the mortgage if you were to die before the end of the term of the mortgage. Most people purchase a combination of permanent and term life insurance.

6.1 Private versus group versus 3rd party insurance

Life insurance is available to private purchasers and members of sponsoring groups. If you are employed, you may have life insurance as part of your employee benefits package. You also may have group life insurance benefits if you are part of a sponsoring union. If you do not have life insurance through your work, or you require additional benefits, you may wish to purchase a private life insurance policy. Life insurance can also be bought by one individual to protect him or herself against the death of another individual. For example, you can take out a life insurance policy on your business

partner, so that you will receive a death benefit if your business partner dies. This is called third party insurance. Actors are sometimes the subject of 3rd party life insurance when a production company takes out an insurance policy on your life or disability to protect themselves if you become ill or die and can't finish a production or fulfil your contract.

You can purchase private life insurance by contacting the insurance agent or insurance company of your choice. The insurance company will provide you with an application in which you must identify your personal circumstances, the type of insurance coverage you are looking for (i.e., permanent or term), the names of the beneficiaries, and how you intend to pay the premiums. It will also include a health questionnaire and a consent allowing the insurance company to speak with your medical professionals and the Medical Information Bureau.

Sometimes people choose only to have term life insurance. If this is the case for you, you should ensure that the term life insurance policy you choose is both renewable and convertible into a permanent policy. If your term life insurance policy is renewable, then you can make changes to your policy before it expires, without having to provide evidence that you are in good health. If your term life insurance policy is convertible, then you will be able to convert your term policy into a permanent policy, without having to provide evidence that you are in good health.

Once you complete the life insurance application, the application will be sent to the underwriting department of the insurance company where it will be reviewed for completeness and assessed for risk. If you are HIV-positive, you will be considered high risk and your application for life insurance will be denied and you will receive a letter advising you that this is the case. If you are found to

be eligible for life insurance, the cost of the insurance will be based on a wide variety of factors. These factors will include your age, health status and the coverage you choose.

Group life insurance plans are usually term insurance. This means that the life insurance policy will expire when the insured is no longer a member of the sponsoring group. In group sponsored life insurance plans there are often probationary periods that must be met (i.e., three months of full time employment) before the group member will be eligible for coverage. Group plans are usually issued without the necessity of a medical exam; however, there are exceptions to this rule where the individual is the member of a small group (fewer than 25 members). When a group member exits a group, he or she should review their life insurance policy to see if it has a provision which allows him or her to convert the policy to a private life insurance policy. See [Section 6.5](#) on Conversion.

6.2 Eligibility

Eligibility for life insurance usually depends on a number of factors. First, will be whether the insurance is offered as part of a group benefits plan, or is individual life insurance. Second, eligibility is also based on an assessment of your risk,. To assess risk, insurance companies look at things like your medical history, your age, whether you smoke and other such factors. Based on these risk factors, the insurance company then determines if they will insure you, and at what cost.

6.2.1 Do I have to have a medical exam?

You will not likely have to submit to a medical exam if you have life insurance as part of your employee benefits at work or if you have life insurance as part of another group. There may be an exception if you work in a small

company or if you wish to purchase additional life insurance on top of what is offered in the basic group plan. There may also be an exception if you are late in filing your application for life insurance, or if your employer neglects to file your application on your behalf in time to the insurer.

You will have to submit proof of good health if you are purchasing private life insurance. The amount of proof will vary considerably depending upon your personal circumstances (i.e., age, family medical history, whether you are a smoker, etc.) and the amount of insurance you are purchasing. The insurance company may be satisfied with a medical history questionnaire that you fill out and sign yourself or they may require a report from your family doctor. If your application is incomplete or suggests a health problem, the insurer may give you a list of medical professionals of their choosing, and ask you make an appointment to be examined by one of those professionals.

When you are purchasing life insurance, you may wish to consider adding a Guaranteed Insurability rider to your policy. This rider may cost a few more dollars than your basic policy but the advantage is that it will give you the opportunity to buy additional insurance in the future without submitting to a medical exam. If you are HIV-positive and you already have a life insurance policy, you should review the policy to determine if you have a Guaranteed Insurability rider. Such a rider would allow you to obtain additional insurance where otherwise you would not be eligible for coverage due to your HIV-positive status.

6.2.2 What do I disclose on the form?

You should be completely honest when completing your life insurance application form. This is because providing misinformation and/or false information on

your application will render your insurance policy void. Omitting relevant information may also render your policy void. If, after submitting your application, you discover or realize that there is wrong or incomplete information in your application, you should contact your insurance company immediately and let them know.

There is legislation in Ontario that holds that an insurance company cannot deny you life insurance benefits because of an erroneous or incomplete application form if two years have passed since the application was completed. There is an exception to this rule in cases of fraud, which is an intentional act to present false information on the part of the insured.

You must report your HIV-positive status on your application for life insurance. If you do not and your insurance company finds out, your policy will be considered void. Even if you were tested anonymously or non-nominally you have an obligation to make a truthful report. Your insurer has extensive experience in gathering information and will likely turn up any information that you are trying to hide.

6.3 Payment of Premiums and Disability Waiver

Most people pay their life insurance every month. However, you may choose to pay your premiums once a year, twice a year or even four times a year depending on your personal circumstances. No matter what payment option you choose, there is a 30-day grace period following the payment due date during which time your policy will remain in force even if you have failed to pay your premium. Your life insurance policy will terminate after the 30 days, if you do not pay your premium within that period. If the death occurs within the 30-day grace period, the life insurance

policy will be paid, minus the overdue premium payment.

If your life insurance policy is terminated for non-payment of premium, you may reinstate your policy within two years of your last payment by paying off the overdue amount plus interest. In addition, you will have to submit new medical evidence.

You may wish to consider purchasing an optional waiver of premium rider when you are buying your life insurance policy. An optional waiver of premium rider in your policy means that your insurance coverage will continue if you become unable to pay the premiums due to disability. Before waiver of premium coverage will start, you will have to meet the definition of disabled as set out in the policy and you will have to have been disabled for a certain period of time. Many group plans with a life insurance benefit have a clause that provides for waiver of payment of the premium while the insured is disabled.

6.4 Living Benefits & Viaticals

Persons living with HIV sometimes become overextended or seriously ill and have difficulty meeting their basic financial needs. This is often seen where individuals do not have insurance or have limited disability insurance. In these cases, if the individual has a permanent life insurance plan, the individual may wish to speak with their employee benefits administrator or insurance company about the availability of living benefits. Living benefits allow a terminally ill individual to get a partial pre-payment (of up 50%) of their death benefit under their life insurance plan.

To be eligible for living benefits you must provide your insurance company with a report from your primary physician confirming that you have a terminal illness and have a life expectancy of 24 months or less. This kind of

report is often difficult to get, given the new HIV/AIDS therapies. Once the insurance company is satisfied on the issue of life expectancy, the insurer will review your policy to determine that the death benefit has not been designated to pay a debt, or left to a beneficiary who may sue the insurance company for the full benefits upon your death. Your insurance company may ask for your consent to contact the named beneficiary to advise them of your application for living benefits.

Insurance companies vary considerably in the administration of living benefits. Some companies have maximum amounts that they will pay in living benefits and others charge you interest on the living benefits. There are also insurance companies that treat the living benefit as a loan and charge you interest in addition to making you continue to be responsible for premium payments. Because of the complexity of the process, you should consult a lawyer or financial advisor if you are considering applying for living benefits.

In some provinces there exist viatical settlement companies that buy life insurance policies from individuals in exchange for a relatively small one-time payment of cash. Some individuals who do not have access to living benefits under their life insurance policy, and who are in serious need of money may consider the viatical option. Viatical settlements are currently illegal in Ontario.

6.5 Conversion from group life to private life insurance

Most group life insurance policies have an option allowing the member to convert the group insurance policy to a private policy, without providing any additional medical evidence, at the time that the insured ceases being a member of the group. You should immediately contact your group insurance

company if your employment ends, to speak with them about converting your group life insurance to an individual policy. As you will no longer be part of the sponsoring group, you will no longer be entitled to life insurance coverage, and you may wish to take advantage of the conversion option. You must submit your conversion application within 31 days of losing your group coverage and you can convert without submitting any evidence that you are in good health. You may also wish to convert your coverage if your employer reduces your group life insurance benefit.

6.6 Claims on Life Insurance: Keeping your named beneficiaries up to date

The beneficiary of your life insurance is whoever you name in your policy to receive the insurance proceeds on your death. Your beneficiary can be a person (i.e., spouse or partner), an organization (i.e., the SPCA), your estate or a trust.

If you choose to designate a person or organization as a beneficiary, the insurance money will go directly to the person or organization you name. If you wish to name a minor child as the beneficiary, you will have to name a trustee to look after the money; alternatively, the proceeds can be paid into court until the child turns 18 at which time the money will be released. If you name your estate, the insurance money will be tallied up with the rest of your assets and your creditors will be paid. Your estate will then be divided up according to the provisions of your will. If you do not have a will, the money will be divided according to the law. However, if you name your spouse, common law or same-sex partner, child, grandchild or parent as a beneficiary, your creditors will not be entitled to any of the insurance money.

6.7 Canada Pension Plan Survivor Benefits

A monthly financial benefit and a small lump sum death benefit are available to the surviving spouse, common law or same-sex partner, and/or dependent children of a deceased person in accordance with the Canada Pension Plan. In order for the surviving spouse or partner and/or dependent children to be eligible for Canada Pension Plan Survivor Benefits, the deceased did not need to apply for coverage before he or she passed away, but he or she had to have made CPP contributions through employment or self-employment. The surviving spouse or partner may qualify for a lesser amount or no benefits at all depending on their age on the date of death of the deceased.

If you are under 35 at the time your spouse or partner died, you can only get survivor's benefits if you had dependent children, or you were yourself disabled. In order to apply for survivor benefits, the applicant must contact Human Resources and Skills Development Canada (1-800-277-9914) to obtain a claim form.

7. Confidentiality: How to keep private information private

Your personal information should not be used by either your employer or your insurer and its representatives for purposes other than to process your insurance application or claim, or for the delivery of benefits. If your insurance company requires information from a third party regarding your circumstances or health status, they will notify you and ask you to provide your consent in writing.

7.1 Dealing with your employer

You have no obligation to advise your employer, supervisor or any of your co-

workers of your HIV-positive status. You may have to discuss with your employer some of the limitations your health condition causes, but you do not have to disclose your diagnosis or specific information about your condition. When you submit an insurance claim, the claim will likely pass through the hands of your employer's office administrator, employee benefits specialist or human resources representative before it is sent to the insurer. In order to prevent any individual in your workplace from reviewing the details of your claim, you may wish to submit your claim directly to your benefits administrator in a sealed envelope. When you submit your claim, you may also want to inform your benefits administrator that you wish the envelope to remain sealed and that it be sent immediately to the insurer.

In the alternative, you may wish to contact the customer service department of the insurance company that issues your group plan and advise them that you wish to submit a claim without the intervention of your employer. You may request that the insurance company accept receipt of the claim directly. Or you may ask if there are any other claims procedures that the insurance company has to protect your confidentiality in the workplace. Be prepared, however, as the insurance company may refuse to accept the claim and may tell you to deal with your employer. If this occurs, and you have little faith in your employer to protect the information contained in your claim, you should contact the Customer Assistance Centre of the Canadian Life and Health Insurance Association at: 1-800-268-8099 and 416-777-2344 in Toronto.

7.2 Dealing with the insurance company

All insurance companies have strict policies regarding the confidentiality of client

information, and are required by law to keep client information private. This does not mean that only one person in an insurance company will know about your claim and medical condition; in fact, your information may be shared and discussed amongst several different people working for an insurance company. What it does mean is that the insurance company must have your written consent to discuss your medical condition with any person who works outside of the insurance company (e.g., your family physician).

If you wish to see the information an insurance company has in its file about you, you can write to the company and request that the information be forwarded to you in the mail. The insurance company may charge you a fee to locate and photocopy this information. If you want to see any medical information contained in your insurance file, you will have to ask the insurance company to release this information to your doctor and you will have to meet with your doctor to review the information. If you get your file and you find it contains erroneous personal information, you should write to your insurance company and advise them of this fact. You should request that they correct the information and then forward you a copy of the amended document.

7.3 The Medical Information Bureau

When you apply for insurance, you will sign a disclosure form that gives your insurance company consent to run your identifying information (name, date of birth, etc.) through a central database administered by the Medical Information Bureau (MIB). The Medical Information Bureau is a non-profit association whose purpose is to allow insurance companies to exchange information about potential clients, in an attempt to prevent insurance fraud.

Where an applicant has a significant medical condition, an insurance company will provide the applicant's health information to the MIB in the form of a brief, coded report. If an HIV-positive person applies for insurance, the insurance company will not only deny their application but they will send information about the applicant's HIV status to the MIB. If the same HIV-positive person applies for insurance through a different insurer, that second insurer will send the identifying information to the MIB and the MIB will advise the second insurer of the HIV status. The second insurer will then deny the application of the HIV-positive person.

If you do not have a significant medical condition, it is unlikely that you will have a file with the MIB. If you want to find out if you have an MIB file, or you wish to see the contents of your file, you should write to the MIB and request that the information be forwarded to you. You can write to the MIB at the following address:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
(416) 597-0590
www.mib.com

8. Appealing Decisions and Resolving Disputes

If you are not happy with a decision that has been made by your insurance provider, or if you are concerned with the actions of the administrator of your group plan at work, you should get organized before voicing your concern. Start by gathering all of the relevant documents, which may include: employee benefits booklets, private insurance policies, applications, claims forms, benefit statements, medical reports and correspondence that has passed between you and your employer or group administrator and your insurer. You should also have a copy of your insurance

company's complaints handling process. This document can be obtained by contacting your insurance agent, insurer or employer. Keep all documents together in a safe place along with a notebook in which you should keep track of any phone calls or contacts you have made, including the names, dates and addresses of the people who have been involved. Read the letters and documents you receive from your insurance company carefully, as they may contain timelines in which complaints and appeals must be filed.

There may be an opportunity to request that an insurance company reconsider a decision that has been made. The insurer will usually inform you if this opportunity exists in their letter of decision to you. If you do request a reconsideration, you should try to get additional evidence to make your case to the insurer and to convince them to change their decision.

If you believe you have grounds for legal action against your insurance agent or insurance company you should contact a lawyer immediately to determine if there is a limitation period which governs the time frame in which you have to file a lawsuit. You should also contact a lawyer immediately if you have applied for benefits and have received a denial letter from your insurer. Otherwise, there are several steps you can take if you wish to try and resolve your insurance problem on your own before speaking with a lawyer.

Remember to keep detailed notes of your resolution attempts including the names and dates of all telephone contacts and information regarding outcomes. You should also make photocopies of all letters that you send to your insurance agent, broker or to a third party including enclosures, and keep copies of all written responses you receive no matter how trivial the responses may appear.

8.1 Steps to Resolution

If you have a dispute with your insurance company, there are a number of ways that you can try to address it. As a general rule, they start by dealing directly with your contact at the company, and move up to the person designated to take complaints at your insurer, and then further up through the Financial Services Commission of Ontario and the Insurance Ombudsperson. As a general rule it is very important to always keep a detailed record of the names of the individuals you speak with, and the dates and times you speak with them. As much as possible, try to make sure that your communication with the insurance company happens in writing, and make sure to keep copies of all documentation that you send to the insurance company. This will all help you in the event of a dispute.

8.1.1 Insurance Company Complaints Ombudsperson

Contact your insurance agent, your insurance agent's supervisor, or the customer service department at the head office of the company where your insurance agent is employed. Each insurance company must have a Consumer Complaint Officer who oversees the handling of all customer complaints. You can find an up-to-date list of the names and contact information for each insurance company's complaints officer on the website of the Financial Services Commission of Ontario (www.fsco.gov.on.ca) and click on "FCO Ombudsman" and follow the links). You can also call (416) 250-7250 or toll-free at 1-800-668-0128. If you wish to file a complaint regarding the unethical conduct of an agent or broker, you should contact the agent's or broker's professional association:

The Financial Advisors Association of
Canada
350 Bloor Street East, 2nd Floor,

Toronto, Ontario M4W 3W8
(416) 444-5251 or 1-800-563-5822
www.advocis.ca

Independent Financial Brokers of
Canada
4284 Village Centre Court, Suite 200
Mississauga, Ontario L4Z 1S2
(905) 279-2727 or 1-888-654-3333
www.ifbc.ca

8.1.2 The Consumer Assistance Centre

If you run into difficulties with your insurance company, you can contact the Consumer Assistance Centre (CAC), which is a non-profit, non-sales help-line in French and English run by the Canadian Life and Health Insurance Association (CLHIA). The Consumer Assistance Centre offers a wide range of services including: information about life and health insurance products and services, company addresses and phone numbers, copies of publications on insurance and dispute resolution services.

You can call the Consumer Assistance Centre free of charge from anywhere in Canada: 1-800-268-8099 or 416-777-2344 in Toronto. Or write to:

Consumer Assistance Centre
Canadian Life and Health Insurance
Association Inc.
1 Queen Street East, Suite 1700
Toronto, Ontario M5C 2X9
www.clhia.ca

After an initial telephone consultation with a counsellor from the Consumer Assistance Centre, you will be given the option of filing a written complaint and having a CAC counsellor contact your insurance company informally to make attempts at resolution based on the information you provide.

8.1.3 The Canadian Life and Health Insurance OmbudService

You also have the option of contacting the Canadian Life and Health Insurance OmbudService (CLHIO), which is an independent service that assists with the resolution of complaints. You should only contact the CLHIO if you have already contacted your insurance company or agent directly, and remain unsatisfied. When you contact CLHIO, an OmbudService officer with training in insurance issues will speak with you and then with your insurance company. The officer will also speak with any other parties they deem necessary and will attempt to solve the conflict. The OmbudService is provided free of charge. If the OmbudService officer is unable to solve the problem to the satisfaction of the parties, the officer will send a non-binding recommendation to the policyholder and the insurance company in writing. If the insurance company refuses to follow the written recommendation of the OmbudService officer, the recommendation will be made public. If you are not satisfied with the recommendation of the officer you can proceed to the next step in the complaint process. You can contact the CLHIO at the following address:

Canadian Life and Health Insurance
OmbudService
1 Queen Street East, Suite 1605A
Toronto, Ontario M5C 2X9
(416) 777-9002 or 1-888-295-8112
www.clhio.ca

8.1.4 The Financial Services Commission of Ontario: The Insurance Ombudsman

You can also contact the FCSO for assistance with a dispute involving your insurance. The FCSO includes the office of the Insurance Ombudsman. Unlike the CLHIO, the FCSO

operates outside of the insurance industry, at arms length from government. This office has a complaints process and you can register a complaint with them. You can call the Insurance Ombudsman free of charge from anywhere in Canada: 1-800-668-0128 or 416-250-7250 in Toronto. Or write to:

Financial Services Commission of
Ontario
5160 Yonge Street, P.O. Box 85
Toronto, Ontario M2N 6L9
www.fsco.gov.on.ca

9. Civil Suits

If you have tried some or all of the steps listed above, and have been unable to reach a satisfactory resolution of your complaint, you should contact a lawyer who can assist you finding out if you can or should bring a legal action to enforce your rights under the insurance policy under which you are claiming benefits. There can be as little as a one-year time limit in which to start a legal action from the time you found out about the disputable event or the disputable event occurred. Even if you are attempting to resolve your dispute through any of the steps listed above, you should contact a lawyer as soon as possible to make sure that you do not lose your right to sue the insurance company if you are not successful in resolving the matter.

You can find a lawyer by asking your friends for a referral, looking through your local yellow pages and/or pink pages or by calling the Lawyer Referral Service (LRS) in Ontario at 1-900-565-4577. There is a \$6.00 charge for using the Lawyer Referral Service billed directly to your phone bill. An LRS operator will listen to a brief description of your problem and will provide you with the name and telephone number of a lawyer in your local area who practices in insurance law. You may make an appointment with that lawyer

directly for a free 30-minute consultation. You can use the LRS service as many times as you like; for example, if you wish to get a second or third option, or until you find a lawyer that you trust. You are not obliged to hire a lawyer just because you have had a free consultation.

Once you have contacted a lawyer, he or she will set up an initial meeting. You should make sure that you bring the following documentation to your initial meeting:

- (a) Employee Benefit's Booklet or Insurance Policy.
- (b) Insurance applications and/or claims forms.
- (c) All correspondence between yourself, your employer and your insurer.
- (d) Full names and addresses of all medical professionals you saw in the five years previous to the meeting, including any hospitals attended.
- (e) OHIP card.
- (f) Employment history or resume.
- (g) A list of your prescription medications. This list may be obtained from your pharmacy.
- (h) A list that you prepare yourself or with the assistance of another individual of your medical conditions and restrictions on activities.
- (i) A list of questions you wish to ask the lawyer and notepaper to write down the answers.

Make sure that you do not give the lawyer original copies of your documentation. Do not leave the lawyer's office without ensuring that you have everything that you brought with you. Be prepared to answer truthfully any questions the lawyer may have for you so that the lawyer can get a full picture about what is going on. Remember the lawyer is a businessperson and is there to serve your needs. Hiring a lawyer is just like choosing a doctor or hiring a caregiver for your children; trust your instincts. If you are not

comfortable, at any time during the meeting with the lawyer, you can leave.

During the initial meeting the lawyer will discuss with you the issue of fees. The fees may either be fixed amount or an hourly rate. As of yet, a lawyer in Ontario cannot directly charge you a percentage of what you win as his or her fees; however, you can attempt to negotiate deferred fees or some other fee arrangement. In addition, you may be responsible for the lawyer's disbursements. Disbursements include such things as court filing fees, witness fees, travel costs, photocopying and faxing costs. Every case is different and therefore no person's legal costs are likely to be the same.

A good lawyer will take the time to listen to your concerns and will also tell you what your rights are and what legal processes are available. The lawyer may not be able to give you an opinion on the outcome of your case as he or she may have to take the time to review your documentation and may have to obtain more information from your primary physician or specialist. If you decide to hire the lawyer, the lawyer will ask you to sign a variety of papers, including a consent form allowing the lawyer to contact your treatment professionals, and a retainer, which will set out the services that the lawyer will provide you with. After you have hired the lawyer, he or she should contact you from time to time to keep you up to date with regard to your case. If you do not hear from the lawyer, you may contact him or her; however, keep in mind that the lawyer should not be contacted about trivial matters as it will take important time away from the more serious issues involved in your case. If you are paying the lawyer an hourly rate, you will be billed for every phone call you make to your lawyer.

You can fire your lawyer at any time. If you wish to fire your lawyer, you should do so by writing a letter advising your lawyer of this fact and requesting your file. You will then be

free to hire another lawyer. If you wish to make a formal complaint about your lawyer, you can contact the Law Society of Upper Canada free of charge at 1-800-268-7568 or 416-947-3310 in Toronto. You can send your complaint in writing to:

Complaints

The Law Society of Upper Canada
Osgoode Hall, 130 Queen Street West
Toronto, Ontario M5H 2N6
www.lsuc.on.ca

Remember that everything you tell your lawyer is covered by solicitor/client privilege. This means that the lawyer is not allowed to release any information that concerns you without your express consent. The lawyer, however, may share your information with his or her colleagues who may, with your permission, help him or her with your case. Once a lawyer is involved, your case may take a couple of weeks or a couple of years to settle depending on your lawyer's and the insurer's strategies and the complexity of the case.