Mapping the Canadian Work Disability Policy System (Alberta and B.C.)

CWRDP BC Cluster Project Report

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# **Abstract**

This study sought to better understand the delivery of work disability benefits in Alberta and British Columbia by documenting and mapping the provision of benefits, and the experiences of individuals with work disability across different providers in both provinces. The research was multi-phased, including: a) an online document review of access procedures, eligibility criteria and type of benefits/coverage for four kinds of work disability benefit providers in each province (workers’ compensation, driver/vehicle insurance, providers of employer LTD benefits, and provincially-administered disability assistance programs); b) in-depth qualitative interviews with work disabled recipients of each benefit programs; c) development of tables comparing similar systems in each province; and, d) refinement of the tables based on interviews with (two) benefit program administrators.

Interviews with work disabled participants reveal that individuals who become work disabled have significant challenges accessing and navigating complex disability benefit programs, often without assistance and necessary information, and that this experience is more complicated and difficult than documented procedures suggest. The themes revealed in the narrative analysis include: “Informational Troubles,” “Navigating Bureaucratic Mazes,” and “Doctors as Gatekeepers.” In addition, we found little if any correspondence between different programs that comprise British Columbia and Alberta work disability income support systems.

# **List of Abbreviations**

AB Alberta

ADLs Activities of Daily Living

AISH Assured Income in Support of the Handicapped

ASEBP Alberta School Employees Benefit Plan

BC British Columbia

BCNU British Columbia Nurses’ Union

BCTF British Columbia Teachers’ Federation

BCPVPA British Columbia Principals’ and Vice Principals’ Association

COLA Cost of Living Adjustment

CPP-D Canada Pension Plan Disability

CRWDP Centre for Research on Work Disability Policy

DABC Disability Alliance of BC

DWC Disability and Work in Canada

EDMP Enhanced Disability Management program (BCNU)

EDP Extended Disability Benefits (ASEBP)

EI Employment Insurance

GWL Great West Life

ICBC Insurance Corporation of BC

LTD Long-term disability

LTDI Long Term Disability Income (Alberta PSC)

PCA Provincial Collective Agreement (BC nurses)

PSC Public Services Commission (Alberta government employees)

PWD Persons with Disabilities

RDSP Registered Disability Savings Plan

SIP Salary Indemnity Plan (SIP)

SFU Simon Fraser University

TTD Total Disability Benefits (ICBC)

UBC University of British Columbia

WCB Workers’ Compensation Board

# **Mapping the Canadian Work Disability Policy System**

The [Canadian] disability income system is an agglomeration of disparate programs that were designed for distinct purposes” (Torjman, 2017, p. 1).

# **Introduction**

This research project sought to address a need identified by the Centre for Research on Work Disability Policy (CRWDP) to better understand the delivery of work disability benefits within and across provinces in Canada. This report focuses specifically those benefit programs administered in British Columbia and Alberta. Disabled people, disability activists and disability policy scholars keenly recognize the fragmented nature of work disability services and support systems, the lack of portability across life transitions or place, and thus the need to develop and enhance the “current patchwork of disability related supports” (Prince, 2009, p. 220. See also Roeher, 1992). A clearer understanding of how these systems function is necessary to identify potential areas for development and enhancement.

In Canada, a person who is work disabled receives benefits determined more by how their impairment developed than by “any rational allocation criteria such as need, contribution, or loss” (Roeher, 1992, p. 1), with each program having “its own criteria for eligibility and its own schedule of benefits and supports” (p. 1). Historically, the disability benefit system was developed in a “haphazard, piecemeal fashion…not designed as integrated or coordinated” (p.8), producing inequity and gaps in coverage; the system treats individuals with similar needs and experiences very differently, with some forms of disability being seen as more deserving than others, and thus receiving different compensation. The clearest example is that disability either attributable to work or traffic accidents is more likely to be treated as compensable than disability resulting from disease or medical conditions are less likely to be considered compensable.

Also, eligibility criteria, benefit coverage and application processes differ from program to program, as does benefit coverage and application processes. Some programs are private, others public; some are contributory, others means-tested; some short-term, others long-term; some support only total disability, others (workers’ compensation) allow for partial support (DWC Steering Committee, 2018). The complex nature of the system and different policies and procedures can be confusing to individuals, creating knowledge gaps that result in failure to access programs to which they may be entitled. Empirical research in British Columbia (or elsewhere in Canada) into the experience of work disabled individuals applying for and receiving benefits is rare and tends to focus on their experience of one benefit program (e.g., Kimpson, 2015; Howse, 2017), not their experience as a whole across program providers or over their disability trajectory.

# **Purpose & Objectives**

The purpose of this study was to develop a clearer understanding of how work disability benefits systems function together (or apart from each other), in both Alberta and British Columbia, by documenting and mapping the provision of work disability benefits across similar providers in both provinces. Part of this purpose was also to understand and describe the pathways that work disabled individuals use to access and receive benefits, and the trajectory of their benefits. British Columbia is one research and partnership cluster within the Centre for Research on Work Disability Policy (CRWDP), with lead investigators located at Simon Fraser University and the University of British Columbia. Ultimately, this research will be linked to similar mapping studies being conducted by CRWDP clusters in Eastern Canada. Alberta and British Columbia were chosen for comparison purposes as they are geographically proximal/neighbouring provinces, with similarities in the organization of disability benefit providers and labour markets, but with differing political and social environments (other provinces will be mapped by other CRWDP clusters).

The objectives of this project were to: 1) conduct a document review and construct process maps of work disability benefits for four provincial benefit providers in both BC and Alberta; 2) validate the process maps through interviews with management representatives from four benefit providers in each province based on their expert opinion/work experiences; 3) validate the process maps by gathering narrative accounts through qualitative interviews with eight to ten individuals experiencing work disability; and 4) identify gaps in the provision and coordination of work disability benefits in each province using data and information from the preceding three study components.

# **Overview of work disability policy programs in Alberta and British Columbia**

This mapping project focused on four different kinds of work disability benefit providers in both Alberta and British Columbia. Each of these programs has different eligibility criteria, application processes and benefit coverage, as follows:

1. **Provincially-administered disability income support**

(Assured Income for the Severely Handicapped (AISH) in Alberta, and Persons with Disabilities (PWD) Benefit in British Columbia (BC)).

Provincially-administered benefits, funded in both Alberta and BC through provincial tax revenue, provide income support for work disabled people who are without employment earnings, are ineligible for employment-based income support programs, including workers’ compensation, and who are unable to rely on social networks for financial support. Provincial benefits are informally known as “last resort” benefits. Typically means-tested, and not subject to income tax, provincial benefits provide financial assistance and other resources beyond welfare benefits. A range of medical and other supports are also available, for which beneficiaries must meet separate eligibility criteria to qualify.

**2. Workers’ Compensation**

(WCB Alberta and WorkSafeBC).

Workers’ compensation is a no-fault insurance program that provides wage loss replacement and medical and rehabilitation benefits to workers who are unable to work due to occupational-caused injury, illness or disease. Provincially-based and administered by independent boards, these programs are typically funded through employer premiums. In addition to wage replacement, workers may be additionally supported to return to the work depending on the nature of illness or injury.

**3. Motor vehicle accident insurance programs**

(Insurance Corporation of BC (ICBC) and private auto insurance in Alberta)

Motor vehicle accident insurance programs are designed to provide wage loss benefits for those who sustain disabling injuries in motor vehicle accidents that prevent them from working. These programs are very different in Alberta and BC; auto insurance in Alberta is a no-fault, tort-based system privately administered through insurance companies. Individuals sustaining disabling injuries are advised to seek legal assistance in order to claim damages and wage loss replacement. ICBC is a provincial crown corporation operating on a for-profit basis, governed by a board of directors that administers the B.C. compulsory public auto insurance program. It offers protection from third-party [legal liability](https://en.wikipedia.org/wiki/Legal_liability), under-insured motorist protection, accident benefits, [hit-and-run](https://en.wikipedia.org/wiki/Hit_and_run_%28vehicular%29) protection, and inverse liability, and is funded by basic auto insurance premiums. Operating as a no-fault system it covers a percentage of wages and medical costs to a person with disabling injuries as a result of a motor vehicle accident. When appropriate, rehabilitation costs supporting return to work are also assumed by ICBC, and claimants have the option of seeking legal help for damages, or if there is disagreement with ICBC’s decisions.

**4. Long-Term Disability Benefit Programs**

(for unionized nurses and teachers, as two significant segments of the labour force, in both provinces).

Employer-sponsored long-term disability (LTD) benefit programs, included in public sector unionized collective agreements, provide income set at a percentage of earnings at the time of disablement for nurses and teachers unable to perform the duties of their occupation due to disabling injury, illness or disease not caused by work. Employers (or the BC Teachers Federation (BCTF)) contract with private insurance corporations to medically adjudicate eligibility for claims/benefits and to make long-term disability benefit payments. Benefit premiums are typically paid by employers on behalf of employees, with the exception of the BCTF Salary Indemnity Plan, where non-taxable benefits are fully funded by BC teachers through the BCTF. Typically, employer-sponsored programs include both short- and long-term disability benefits, with claimants required to exhaust sick leave benefits, employment insurance (EI) medical benefits and short-term disability benefits before becoming eligible for LTD benefits. In BC, teachers who may be able to return to work are assisted by BCTF with accommodative employment, and may be assigned a rehabilitation consultant to manage this transition.

# **Methodology & Research Design**

All research procedures were approved by Simon Fraser University’s Office of Research Ethics (ORE – Study #: 2017s0403).

## **Benefit Program Document Review**

Initially, we conducted document review of each benefit program under study. Publicly-available online information from five benefit providers in each province was used to create tables depicting: a) eligibility criteria for benefits; b) access processes to the applicable benefit system, including referral processes for services both within and across providers; and, c) coverage available to applicants, including income and medical benefits, qualifying periods, benefit caps, and time restrictions. Tables comparing similar programs in both provinces using these parameters were also created (See Appendices for tables comparing details about Access, Eligibility and Coverage for individual programs).

Benefit programs studied include: provincially-administered disability assistance (Alberta AISH and BC Benefits); WorkSafeBC and Alberta-WCB; Alberta private vehicle insurance and ICBC; and employer-sponsored long-term disability [LTD] benefits for unionized nurses (Alberta Public Service and BCNU), and teachers (ASEBP and BCTF) in each province.

## **Qualitative Interviews: Description of Population**

People who are considered work-disabled access different disability benefit providers depending on whether they are working at the time of illness or injury, whether the illness or injury is work-related or not, whether it is the result of a motor vehicle accident, or if they have an informal or unstable attachment to employment. Also, the experience of navigating benefit systems can differ depending on the type of impairments one lives with. Given these variables, individuals with different kinds of impairments resulting in work disability were purposely included in the study, as follows: work-related musculoskeletal injury (e.g., spinal cord injury, back strain); mental health condition (e.g., depression with anxiety, PTSD); chronic, degenerative disease (e.g., multiple sclerosis, chronic fatigue) with unpredictable, episodic symptoms; and an acute, vehicle-related injury (e.g. spinal cord injury, severe concussion). Individuals with chronic, cumulative or episodic conditions are the most likely to rely on multiple providers over their disability trajectory, and most likely to experience gaps in coordination of benefits across providers from a systems perspective. Musculoskeletal disorders (e.g. back strain) and mental health conditions also represent two predominant sources of work disability across benefit providers, while spinal cord injuries and chronic diseases such as MS represent less prevalent forms of work disability. Both adult males and females of different age groups were included in the study. (See Table 1: Work Disabled Research Participants, for details below).

## **Interview Methods**

Nine work disabled participants (three in Alberta and six in B.C.) who had successfully applied for and were receiving work disability benefits from one of the above-mentioned providers, were recruited using snowball sampling and informal community-based disability support networks. Each signed a Participant Informed Consent Form (copies available upon request) that included pertinent details about the study and their participation. These forms were returned to the Principal Investigator either electronically or in-person, depending on the medium of the interview. Recruitment in Alberta proved challenging such that a work disabled teacher and a worker receiving workers’ compensation benefits were not recruited from this province to participate in interviews about their disability experience. In addition, the Albertan former nurse who participated in the study was unexpectedly not a member of the Alberta Nurses’ Union (UNA), rather the Alberta Public Service. The Alberta participant who had sustained disabling injuries in a motor vehicle accident had been completely at fault. As such, this participant was ineligible to seek damages through private vehicle insurance, so applied to and received funding through the Alberta Motor Vehicle Accident Claims Program to purchase wheelchairs and make their home fully accessible. His data was relevant to the study purpose, particularly his experiences of different income support programs and engagement in further education and employment, and was included in the study analyses.

During the audio-recorded semi-structured qualitative interviews, conducted either in person, via phone or Skype, participants in each province were asked about their lived experiences accessing work disability benefits and interactions with benefit providers in their province, and the benefits and coverage they receive. (See Appendix A for Participant Interview Guide). The principal investigator of this study (Kimpson) has been work disabled, and has direct experience of work disability benefit programs. Along with her personal experience, she brings considerable research experience conducting qualitative interviews and interpretive analysis.

**Table 1: Work disabled research participants from British Columbia and Alberta, interviewed on benefit program experiences**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender | Location | Occupation | Age | Impairment | Benefit |
| M | Alberta | Farming/labourer | 50s | Paraplegic, blind (MVA) | AISH/CPP/Alberta MVA Claim Fund (lifetime limit $100,00 for assistive devices and renovations) |
| F | Alberta | Homemaker (3 children, two on autism spectrum) | 40s | PTSD (abusive spouse)/autism spectrum | AISH |
| F | Alberta | Registered nurse, community mental health | 40s | dissociative identity disorder, not otherwise specified (DDNOS); chronic back strain; impaired mobility (uses wheelchair) | Alberta Health Services LTD |
| F | BC | Registered nurse | 50s | Back injury; colo-rectal cancer | BCNU LTD |
| F | BC | University student; part-time barista | 20s | Acquired brain injury due to MVA (on bike) | ICBC |
| F | BC | Grad student; social services worker | 30s | Chronic anxiety & depression; chronic fatigue and fibromyalgia | BC PWD |
| F | BC | High school teacher, at-risk students | 40s | Chronic fatigue/fibromyalgia: postural orthostatic tachycardia syndrome (POTS) | BCTF LTD |
| F | BC | Unionized railroad track maintainer | 40s | Spinal cord injury, C4 & C5; ambulatory with ongoing neuro symptoms | WorkSafe BC |
| F | BC | Middle school principal | 40s | Multiple sclerosis | BC Principals and Vice Principals LTD (same as BCTF) |

The interviews were designed to generate narrative accounts of: a) each person’s disability, and their understandings of how their impairment fits with eligibility criteria; b) their experience of applying for and accessing benefits, and any gaps/concerns; and, c) the coverage/benefits they received, and any gaps/concerns. An honorarium was provided to each of the work disabled participants. Interviews with work disabled participants were subsequently transcribed by the principal investigator, and participants’ accounts of their experiences were also analyzed by the principal investigator, using narrative policy analysis.

Narratives are considered one of the “richest vehicles for the multiple and complex meanings” (Lejano, 2012, p. 103) brought to any policy issue by various stakeholders, including work disabled individuals whose lives are governed by particular policies. Work disabled participants’ first-person accounts take shape as narratives (Kohler Reissman, 1993) and reveal how these individuals articulate and make sense of the processes each program requires them to engage in.

The principal investigator reconstructed participants’ accounts in ways that reflect salient aspects of their experiences in an empirically verifiable, rich and coherent narrative fashion for the purposes of the study. Interpretively, the reconstructed narratives constitute different aspects of each work disabled individual’s experiences in ways that cohere or reveal the connections among the different accounts. These narratives are data rich, compelling and provide a clear description and understanding of the pathways—and side trips—each of the work disabled participants experienced. The narratives appear in Appendix H: Work Disabled Participant Narratives.

During analysis, the principal investigator paid close attention to how work disabled participants spoke about their encounters with work disability programs in order to discern both differences and commonalities, thematic patterns/tendencies, and how these situated narratives were created and shaped in ways that reflect their interests and concerns as participants in these programs.

## **Interviews with Management Representatives**

Interviews with management representatives from each of the disability income support program providers were designed to validate the information on their websites, understand typical decision pathways and critical junctures for applicants to their programs, and identify gaps in the delivery/coordination of benefits within and across providers from a systems perspective. When relevant, aspects of work disabled participants' experiences reflected in the narratives were presented for comment. Interviews with work disability program providers commenced once the disabled participant interviews were completed, transcribed and narrative analysis conducted, in order to be able to use this data to inform provider interviews. Once a contact person was determined for each provider (with permission from the provider, where appropriate), the researchers approached recruitment by sending a description of the project, a copy of the Informed Consent form, and a list of guiding questions for the interviews, each tailored to the specific provider. (See Appendix B: Interview Guide for Providers).

Difficulty was encountered recruiting management representatives from most of the providers, despite persistent efforts over a lengthy period by the research team. For example, one provider, who expressed enthusiastic support for the project, ultimately decided not to participate, citing timing and workload of senior managers in the operating division, who would have been the best resource to provide information regarding organizational processes. Managers conversant with WorkSafe BC policy would have been able to participate, but given our focus on provider practices, this did not meet our requirements. An Alberta WCB manager was successfully recruited, but was not interviewed because we were unable to recruit a work disabled recipient of these benefits.

Ultimately, semi-structured qualitative interviews were conducted with two management representatives, one a former director at ICBC and the other a manager of service delivery at the BC Ministry of Social Development and Poverty Reduction, which delivers disability benefits to eligible British Columbians. A professional transcriber was used to transcribe the two provider interviews that were then summarized by the principal investigator, and served as a comparison to the work disabled participant data and the online document review data.

# **Results**

A list of work disability programs under study in BC and Alberta, with basic program details, was provided in the Overview of Work Disability Policy section (pp. 8-10). The following section provides details on access to information, formal eligibility criteria, application processes and benefit coverage for each of the programs under study. It is followed by a presentation and then discussion of the key findings of the qualitative interviews of participants with work disability, including examples depicting their experiences and pathways through different systems.

## **Benefit Program Details**

### 1. **Provincially-administered disability benefits**

[Note: A comparative table describing access, eligibility criteria and coverage for BC PWD Benefits and AISH benefits appears in Appendix C]

Reference to limits, coverage, eligibility values, waiting times or periods are current.

Funded in both Alberta and BC through provincial tax revenue, these programs provide income support for work disabled people who are without employment earnings, are ineligible for employment-based income support programs, including workers’ compensation, and those who are unable to rely on social networks for financial support. Notably, both provincial programs in Alberta and BC require a financial eligibility assessment prior to being assessed medically for the benefit. Often this includes an initial financial eligibility assessment for basic social assistance, typically more stringent than the assessment for AISH or PWD, whose allowable assets (for a single person) in both provinces are $100,000. Alberta has allowed this asset limit since 2005, and BC since 2015.

Both provincial programs provide a monthly benefit (in Alberta a “living allowance”) that falls well below the Market Based Measure[[1]](#footnote-2) (used to determine Canada’s official poverty line), with British Columbians receiving PWD benefits percentage-wise further below the poverty line percentage-wise than Albertans receiving AISH. Both programs allow beneficiaries to engage in employment, and retain employment income up to an annualized limit, but an applicant typically cannot be working at the time they apply for benefits (although the language on the AISH website is ambiguous). In its definition of disability for official purposes, Alberta includes criteria related to limitations in ability to earn a livelihood, while BC bases the definition of disability on an individual’s ability to perform Activities of Daily Living (ADLs) and whether they require assistance to do so.

#### **a) British Columbia: Persons with Disabilities (PWD)**

The BC Employment and Assistance Program for Persons with Disabilities provides financial assistance and other resources beyond regular welfare benefits. Eligibility is not based on prior employment, nor being medically unable to work included in criteria, and is means-tested, with detailed financial eligibility criteria (see below). BC requires applicants who potentially qualify for Canadian Pension Plan Disability (CPP-D) benefits to apply for it once provincial PWD benefits are approved. If successful, B.C. provides the difference calculated between the CPP-D benefit and the provincial benefit, up to the provincial benefit total. PWD benefits are not subject to income tax, but CPP-D benefits are.

##### *Eligibility*

To be eligible for disability assistance, a person must meet the criteria for the Persons with Disabilities (PWD) designation and be designated as such by the ministry. The purpose of a PWD designation is for individuals to access assistance or programs under the Employment and Assistance for Persons with Disabilities (EAPWD) Act. PWD is not a permanent designation and the Ministry has the authority to rescind an individual’s designation status. Recipients retain the PWD designation whether or not they continue to be financially eligible for disability assistance. They are not required to apply for the designation upon reapplication for assistance.

In order to apply, each applicant must first meet the financial criteria for applying for PWD, which means submitting hard copies of financial statements to their regional Ministry office, to be reviewed and assessed by Ministry staff. Once this assessment is completed and approved, applicants must attend the Ministry office again to request and receive a hard copy of the PWD Designation Application form.

Formal eligibility criteria for BC PWD benefits include:

i) financial eligibility must be met. The general asset exemption limits are $100,00 for a single person with the PWD Designation ($200, 000 for two disabled adults in a family). Asset limit exemptions include, a person’s home, one motor vehicle, clothing and necessary household equipment, a Registered Disability Savings Plan (RDSP), and/or assets held in a qualifying trust;

 ii) be at least 18 years of age (and no older than 65 years);

 iii) have a severe physical or mental impairment that in the opinion of a medical practitioner or nurse practitioner (NP) is expected to continue for at least two years;

iv) in the opinion of a prescribed professional (Registered Nurse or Registered Psychiatric Nurse, Social Worker, Registered Psychologist, Occupational Therapist, Physical Therapist or Chiropractor), be significantly restricted in ability to perform activities of daily living, either continuously, or periodically for extended periods; and

v) require assistance with daily living activities from: another person, or with an assistive device, or require the significant help or supervision of another person, or an assistance animal (whether or not assistance is received).

##### *Access & Information*

Individuals in BC wishing to apply for provincial disability benefits can find information about the program either through the BC Ministry of Social Development & Poverty Reduction website (<https://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/disability-assistance>), at regional Ministry offices, or through non-profit societies supporting people with disabilities. For example, The Disability Alliance of BC (DABC) has developed a range of BC Disability Benefits Help Sheets, including a PWD application Guide. These are posted online for those needing information about applying for benefits. (See: <http://disabilityalliancebc.org/category/publications/help-sheets/>) These DABC Help Sheets are also made available to various non-profit groups around BC supporting those needing financial assistance, for example, the Together Against Poverty Society. Advocates at both these agencies also provide assistance to those wishing to apply for PWD Benefits. The Ministry can designate someone as a Person with Disabilities (PWD), without going through the standard application process, if the person has already been approved for another prescribed government program or benefit, such as receiving palliative care benefits, eligible for CPP-D benefits, enrolled in the Developmental Disability or Personal Supports Initiative, or eligibility for the At Home Medical Benefits and Respite Program.

Once financial eligibility is established, an applicant for PWD Benefits must apply for the PWD Designation by completing the applicant portion of the 28-page PWD designation application booklet and form in hard copy. Applicants can speak with a Ministry worker via phone or in person to request an application form. Applicants are also required to have the Physician section of the form completed by a doctor or NP, and the Assessor portion of the form completed either by a doctor/NP or a prescribed professional. After the application is completed and submitted, it is reviewed by the Ministry, who informs applicants whether or not they meet the eligibility criteria for the PWD designation.

##### *Coverage*

As of April 1, 2019 the monthly benefit amounts (including $375 monthly shelter allowance) are:

 Up to $1,183.42 if you are single

 Up to $2,073.06 if spouse also has the Persons with Disabilities designation

 Up to $1,609.08 if a single-parent family with two children

Recipients of disability assistance who meet the Ministry of Health (MOH) residency requirements are provided with premium-free MOH medical coverage through Medical Services Plan, and PharmaCare (prescription coverage) with no deductible

The Ministry of Social Development and Poverty Reduction, Health Assistance Branch provides specified health supplements to all recipients of disability assistance who meet the eligibility criteria for each supplement. For a summary of health supplements for which recipients may be eligible see: <http://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/health-supplements-and-programs/health-supplement-summary>

Applicants are also expected to pursue and accept other means of support, i.e., EI Sickness Benefits and/or CPP-D. Clients are asked to provide to the Ministry with a Statement of Contributions (to CPP) from former employers that the Ministry CPP Program Services team review to determine if the client meets CPP contribution requirements. If a client meets these requirements, the Ministry sends a CPP-D package to be completed by the client and physician. The completed CPP-D application package is then returned to the CPP Program Services team at the Ministry, who make sure it is complete before forwarding it to CPP-D on behalf of the client. PWD applications are not currently available to be completed online, nor is the PWD benefit portable between provinces.

Those with the PWD designation can still work and earn money without altering the benefit up to a certain amount. The annual earnings exemption applies to money earned between January 1–December 31, with a new exemption limit beginning each year. The current exemption limits are:

$12,000 for a single person with the Persons with Disabilities designation

* $14,400 for a family with two adults where only one person has the Persons with Disabilities designation

$24,000 for a family where both adults have the Persons with Disabilities designation

The annual earnings exemption can be used at any time during the year, and does not affect the monthly assistance amount until more than the annual limit for that calendar year is earned. Any income over the annual earnings exemption limit is deducted dollar for dollar from the assistance benefit. Beneficiaries can keep 100 per cent of the money earned, and receive a letter after earning 75 per cent of the exemption limit, informing them they are reaching the upper annual exemption limit.

#### **b) Alberta: Assured Income for the Severely Handicapped (AISH)**

##### *Eligibility*

Formal eligibility criteria for AISH benefits include:

 i) at least 18 years of age and not eligible to receive an Old Age security pension;

 ii) live in Alberta and are a Canadian citizen or permanent resident;

 iii) do not reside in a correctional facility or a mental health facility, like Alberta Hospital Edmonton;

 iv) have a medical condition that is likely to remain permanent, and is the main factor limiting ability to earn a living;

v) apply first for all other eligible income, e.g., CPP-D, EI Sickness Benefits or WCB; and

vi) have no assets in excess of allowable assets allowed by AISH.

##### *Access & Information*

Individuals in Alberta wishing to apply for provincial disability benefits can find information about the AISH program and how to apply for benefits on the Ministry of Community and Social Services AISH website. [See: <https://www.alberta.ca/aish.aspx>] Applications can be completed either electronically online using documents on the AISH website, or applicants can print the Application form and complete it for submission either by mail or in person at Ministry offices. Like BC, non-profit societies in Alberta, such as the Alberta Paraplegic Association (now Spinal Cord Injury Alberta) has advocates who assist with AISH applications. Interestingly, unlike BC, Alberta has an Office of the Advocate for Persons with Disabilities that represents the rights, interests and well-being of Albertans with disabilities, and a Premier’s Council on the Status of Persons with Disabilities.

The application form has two substantial sections to be completed by applicants, not seen on the BC PWD Application form: Employment History and Education/Training History. Income and Asset information are also completed on the form, and verified by submitting copies of supporting documents online. In BC, hard copies of income and asset documents must be provided to the Ministry at their offices. AISH applicants also consent to have a CPP-D representative determine eligibility (or not) for CPP-D benefits and communicate that decision with AISH. The applicant consents to an exchange of personal information, including their completed AISH application, between the two benefit providers. A physician completes the

AISH medical report that includes space for descriptive information. The AISH benefit is not portable between provinces. Unlike BC PWD, AISH states that applicants can work and be eligible for AISH; in fact “clients are encouraged to work to the extent they are able” (<https://www.alberta.ca/aish-eligibility.aspx>).

##### *Coverage*

AISH provides a living allowance, personal benefits, health benefits and child benefits.

*Living Allowance*

Standard: For those who rent or own a home, apartment or condo; live with family or friends; live in a private group home, or are homeless, the amount depends on any other income that the applicant or spouse or partner may have; maximum of $1,588 per month

Modified: For those who live in an approved nursing home, auxiliary hospital or designated supportive living facility (DSL), the amount depends on any other income that the applicant or spouse or partner may have. Benefits include a personal needs amount up to $315 per month and an accommodation rate, as follows: private room rate of $1,950 per month for nursing homes, auxiliary or active treatment hospitals when a daily rate is charged, approved DSL facilities, standard room rate of $1,601 per month for approved DSL units in lodges.

Child Benefit: $100 per month for each dependent child; to be eligible applicants must have no more than $3,000 in non-exempt assets such as cash, investments, bonds or be in a financial hardship situation.

Health Benefits (for those who do not have coverage through other government programs): Includes prescription drugs from Alberta Drug Benefit List, some over-the-counter items, and nutritional products. It also includes diabetic supplies, emergency ambulance trips, subsidy for Alberta Aids to Daily Living (AADL), basic dental work (check-ups, cleaning, x-rays, fillings, extraction, dentures), and other dental services, and optical benefits (eye exams every two years, plus one pair of glasses for adults, every year for children)

Personal Benefits: Provides benefit expenses for specific needs over and above the monthly living allowance for applicant and dependent children. Includes addictions treatment; equipment maintenance for wheelchairs and scooters; health services such as acupuncture, chiropractic, massage therapy and physiotherapy; medical alert service; medical equipment not available through the AADL program or other sources such as private insurance or temporary equipment loan programs (e.g., orthotics, BP monitor, canes/crutches, heating pad; hearing aid batteries, CPAP & supplies, splints, braces); home care or wound clinics; specialized clothing adapted for a disability; and special diets.

Other personal benefits: Provides children’s benefits for help with infant and child care or children’s education; emergency benefits to help deal with an emergency situation beyond a person’s control; escaping abuse benefits to help move and set up a new home; employment and training expenses; funeral benefits; moving benefits to set up a new home; travel benefits for health-related services, court attendance and training; food and routine veterinary services for an approved service animal

#### **2016 Alberta Auditor General’s Report**

This report included an examination of the department that oversees AISH (Human Services). In particular the AG looked at

the department’s systems and processes for ensuring the program is easily accessible to eligible Albertans and how it applies clearly defined criteria in compliance with legislation and policy when making eligibility decisions. Our audit included the application process and various systems in place around eligibility decisions. (Saher, 2016, p. 6)

The Auditor General concluded that the Department of Human Services

is unable to demonstrate that the AISH program is efficient. The AISH application process favours people who are good at completing forms and are persistent. Assessing eligibility takes too long, and the department cannot be sure its staff’s decisions are consistent. With its existing reporting process, the department does not know what it needs to change to improve the program. (Saher, 2016, p. 6)

Notably, the audit of the Department’s processes found that on average it takes 203 days from receipt of the application form to approval of AISH eligibility. Detailed recommendations for improving these (and other) aspects of the AISH program are included in the Auditor General’s report (Saher, 2016, pp. 31-46).

### **2. Workers’ Compensation programs: WorkSafeBC and Alberta-WCB**

[Note: A comparative table describing access, eligibility criteria and coverage for WorkSafeBC and Alberta Workers’ Compensation appears in Appendix D: WCB Work Disability Programs].

Workers’ Compensation is basically a no-fault insurance program that provides wage loss replacement and medical benefits to workers who are unable to work due to occupational injury or disease. Provincially-based and administered by independent boards, these programs are typically funded through employee/employer premiums (although Alberta Workers’ Compensation is entirely funded by employers). Workers may be supported to return to the workplace depending on the nature of illness or injury.

#### **a) WorkSafeBC**

Employer-based contributions cover employees for work-related illness or injury. Compensation types vary depending on type of injury, illness, disease or disability. Rehabilitation services are offered in some cases, and compensation programs can be time-limited. Monetary compensation is non-taxable and in BC indexed to cost of living minus 1% of the annual Cost of Living Allowance (COLA) change from year to year.

##### *Eligibility*

Eligibility for WorkSafeBC benefits hinges on a person being a worker employed by an employer covered by the BC Workers’ Compensation Act, and that the condition resulting in work disability was more-likely-than-not caused by work/working conditions. Some segments of the workforce are not covered or covered under different insurance programs, and some workers (e.g. self-employed) can opt out of coverage. In the case of injuries, compensation is limited to personal injuries arising out of and in the course of employment. There are two general categories of injury: personal injury (including psychological impairment) and occupational disease (e.g., cancer, respiratory conditions, contagious diseases). Workers may be entitled to health care benefits for as long as they continue to experience the effects of the compensable injury or disease, but not all consequences of employment-related injuries are compensable.

With respect to occupational disease, there is no definition of “disability” in the Act. There must be some loss of earnings from regular employment as a result of the disabling effects of the disease, and not just an impairment of function. A worker will be considered disabled for the purpose of wage-loss compensation when they are no longer able to perform their regular employment duties, and as such would in the ordinary course sustain a loss of earnings as a result.

##### *Access & Information*

Information about making a WorkSafeBC claim is usually available at a person’s place of employment and/or provided by the employer, via physicians or health care providers and can also be accessed on the WorkSafeBC website [<https://www.worksafebc.com/en/insurance/apply-for-coverage>]. In order to access WorkSafeBC compensation, workers must report the injury to their employer as soon as possible after it occurs, see a physician, and then report the injury to WorkSafeBC using the Application for Compensation and Report of Injury or Occupational Disease form. This form, once completed, can be submitted online, by mail or by fax. A claim number is issued at the time of reporting. According to the WorkSafeBC website [<https://www.worksafebc.com/en/insurance/apply-for-coverage>] approximately ten (10) business days is required for WorkSafeBC to gather information, review the application and notify workers of any decision made.

##### *Coverage*

In terms of coverage, WorkSafeBC monetary compensation is non-taxable and indexed to the cost of living minus 1% of the annual COLA change from year to year. Wage loss benefits are payable when injury or disease causes temporary disability from work, and may be total or partial. These benefits usually commence shortly after the initial acceptance of a claim and cease when the worker recovers from injury and is able to return to work, or the condition becomes permanent, in which case the worker is assessed for a permanent disability award. Wage loss benefits are calculated on the basis of a worker’s average net earnings. A variety of types of compensation are provided (see Appendix D) including wage loss replacement, permanent disability awards, pensions to dependents (deceased worker), health care benefits, and rehabilitation assistance. CPP-D basic benefits are deducted from a worker’s permanent disability award only.

#### **b) Alberta Workers’ Compensation (WCB-Alberta)**

The Alberta Workers’ Compensation (WCB) program (from the information publicly available on the website) operates similarly to WorkSafe BC.

##### *Eligibility*

Eligibility depends upon whether an injury arises out of and occurs in the course of employment. Employees are covered whether they work full time, part time, temporarily or casually, and there is no waiting period for coverage to begin, beyond the first day off for wage loss.

##### *Access & Information*

Information regarding making a claim is usually available at a person’s place of employment and/or provided by the employer, and can also be accessed through health care providers or on the Alberta WCB website [<https://wcb.ab.ca/assets/pdfs/workers/WCB-003_Worker_Handbook.pdf>].

Workers are encouraged to report the injury or occupational disease as soon as possible to their employer. Legally, the employer, once notified is required to report the injury to WCB within 72 hours if the worker needs medical treatment beyond first aid, or cannot perform their job beyond the day of the injury/disease. Workers are required to inform their physician or other health care provider that they were injured at work, who in turn must report the injury to WCB within 48 hours. The worker is expected to complete and submit a report of injury form to WCB online or via fax as soon as possible following injury. Specific to Alberta, information regarding a person’s location is required if the worker normally resides in Alberta, but sustained the injury outside the province, or if the worker normally lives outside Alberta but was injured in Alberta. An AB-WCB adjudicator confirms eligibility for benefits, and a case manager may be assigned if the worker needs time off work. The case manager helps the worker develop a rehabilitation and return-to-work plan.

##### *Coverage*

Coverage includes non-taxable wage replacement benefits (based on 90% of net earnings) for those unable to work due to injury. Like WorkSafeBC there is a cap on these wage-replacement benefits. Wage replacement benefits start the next working day after injury. Workers can leave Alberta for a short time if the doctor and WCB confirm the trip will not delay recovery. A move from Alberta to another province is allowed provided it does not delay recovery and return to work and the worker remains in regular contact with Alberta WCB. WCB co-ordinates and pays for necessary health care services, including personal assistance when needed, and travel and accommodation expenses. There was no mention of offset related to CPP-D on the publicly-available Alberta WCB website, and Alberta Health Care coverage costs are the responsibility of the worker when injured and not working. Those who have lost a body part, the use of a body part, system or function may be entitled to a lump sum payment. Impairments are assessed by a physician at approximately two (2) years after a return to work or latest surgery to determine eligibility for this payment.

### **3. Motor vehicle accident insurance programs (private insurance in Alberta and ICBC in British Columbia)**

[Note: A comparative table describing access, eligibility criteria and coverage for ICBC Benefits and Alberta Motor Vehicle Accident insurance appears in Appendix E: Auto Insurance].

Motor vehicle accident insurance programs are designed to provide wage loss benefits for those who sustain disabling injuries that prevent them from working. These programs are very different in Alberta and BC as outlined in detail below.

#### **a) Insurance Corporation of BC (ICBC)**

ICBC is a provincial crown corporation operating on a for-profit basis, governed by a board of directors that administers the BC compulsory public auto insurance program, or Autoplan. It offers protection from third-party [legal liability](https://en.wikipedia.org/wiki/Legal_liability), under-insured motorist protection, accident benefits, [hit-and-run](https://en.wikipedia.org/wiki/Hit_and_run_%28vehicular%29) protection, and inverse liability, and is funded by basic auto insurance premiums. Operating as a no-fault system it covers a percentage of wages and medical costs to a person with disabling injuries as a result of a motor vehicle accident. When appropriate, rehabilitation costs supporting return to work are also assumed by ICBC, and claimants have the option of seeking legal help for damages or if there is disagreement with ICBC’s decisions. Individuals BC, as well as Alberta, who sustain disabling injuries are advised to seek legal assistance in order to claim damages and wage loss replacement.

##### *Eligibility*

Generally, any driver, passenger, pedestrian or cyclist who themselves carries Basic Autoplan insurance from ICBC, including Basic Underinsured Motorist Protection, and is injured or disabled as a result of a vehicle accident in BC, or any B. resident with Autoplan insurance injured or killed in a motor vehicle accident in North America, is entitled to benefits from ICBC. In addition, any cyclist or pedestrian hit in Canada by a vehicle licensed and insured in BC is entitled to ICBC benefits.

##### *Access & Information*

Detailed information about making a claim is on the ICBC website at:

https:// [www.icbcclaiminfo.com](http://www.icbccaliminfo.com)

Legally, ICBC must be given notice of a claim for benefits promptly after an accident, online or by phone. Written notice of the accident particulars and consequences (injuries) must be given within thirty (30) days of the accident. An ICBC form, “Accident Benefits Application Form” is generally used to provide the required information about the accident and injuries. Usually a brief report is required by the physician to confirm the person is unable to work. An ICBC Claim Specialist is assigned to the claimant and will answer questions and guide the injured party through the claim.

An ICBC adjuster investigates the accident and decides liability. The adjuster will also review the injured person’s medical information and expenses. An injured party might wish to consult a lawyer before talking to ICBC; the lawyer can also report the claim to ICBC. Also, if there is disagreement about ICBC decisions (about fault or damages), a lawyer should be consulted for advice, to consider whether or not suing the owner and driver of the other car for tort damages is the best course of action. Tort legal action must commence within two (2) years from the accident date, or if receiving no-fault benefits, two (2) years from the date of the last benefit payment.

##### *Coverage*

[See: <http://www.icbc.com/autoplan/Documents/autoplan-insurance-brochure.pdf>]

When a person is injured in a motor vehicle accident they are entitled to medical benefits, rehabilitation benefits and wage loss benefits. In terms of medical benefits, ICBC is required to pay all “reasonable” and “necessary” medical expenses, including therapy (e.g., physio and/or massage) to a limit of $150,000 for each insured person injured. ICBC may cover costs for treatment or items likely to promote the rehabilitation of an injured person, and has more discretion with respect to these expenses than medical expenses. Rehabilitation benefits may include home renovations, attendant care, wheelchairs and the purchase of a motor vehicle, for example. If an injured person has a group health or private health plan these must be used first before seeking benefits from ICBC. For serious injuries, rehabilitation requires a team of professional rehab coordinators (from ICBC) to assist with recovery. The rehabilitation coordinator works with the injured/disabled person, his/her physician, in consultation with medical specialists and therapists, to design the best possible treatment plan.

If an accident or injury prevents a person from working, ICBC provides wage loss benefits called Total Disability Benefits (TTD). These benefits are available to an employed person who is unable to work because of a total disability caused by a motor vehicle crash. An employed person is defined as someone who had a job on the date of the crash, or someone who did not have a job on the date of the crash but who worked at least six of the twelve (12) months preceding the disabling motor vehicle crash. There is a seven (7) day waiting period for these benefits, extended when the individual is entitled to EI Sickness Benefits (usually fifteen weeks). Individuals to whom this applies are encouraged to apply for EI Sickness Benefits immediately after an accident because of the two-week waiting period for the EI benefits (or confirmation they are not entitled to EI). Once EI Sickness Benefits begin, the EI amount will be deducted from any TTD entitlement.

Total Disability Benefits are capped at $740/week, calculated at 75% of average gross weekly earnings in the fifty-two (52) weeks before the accident. For those who work part time, the employment history formula for calculating TTDs may result in ineligibility or modest TTDs. If the injured person has other disability coverage TTDs can be used to top up the total benefits to 75% of average weekly earnings. Also, if the person unsuccessfully attempts to stay at or return to work this does not prevent them from TTD entitlement. The injured person is entitled to receive TTDs for a period of two (2) years (104 weeks) after the accident. Beyond this time period they are entitled to continue TTDs only if they cannot do any job to which they may be suited based on their age, education, and employment experience. TTDs beyond two years are payable up to the age of 65 years. For those who receive TTD benefits beyond two years, ICBC can require the injured person to apply for CPP-D, and if successful the TTDs are reduced by the CPP-D basic benefit.

*Damages*

From the Canadian Bar Association British Columbia Branch website: <http://www.cbabc.org/For-the-Public/Dial-A-Law/Scripts/Automobiles/188>

If the accident causing injury was determined not to be the fault of the injured person (or only partly at fault), they can seek damages for pain and suffering, lost wages (past and future), future care, out-of-pocket expenses, and other losses. This is called a tort claim. These damages aim to put an injured person who did not cause the accident in the same position they would have been in if the accident had not happened (as far as money can do this).

ICBC will typically offer injured parties money to settle or resolve claims. Normally injured parties are advised not to settle a personal injury claim until their medical condition is stable and their doctor is able to say when the injury will probably be resolved, and whether there will be any lasting effects. Then, if the injured party agrees with ICBC’s offer, the claim can be settled, and is considered final. This finality applies even if the person later suffers new, unexpected effects from the injuries. A “full and final release of all claims” has to be signed before receiving the settlement money.

#### **b) Alberta Motor Vehicle Accident Insurance**

Very little information about Alberta MVA insurance is publicly available, given the system in Alberta is privatized. Albertans choose their motor vehicle insurance package depending on need and cost. We could find no general information from the websites of Alberta insurance brokers from websites. However, the Insurance Bureau of Canada has some general information and information specific to Alberta (and other provinces) on their website [<http://www.ibc.ca/ab/auto/auto-insurance>].

##### *Eligibility*

Those who own or drive a car in Alberta, by law, must purchase valid liability insurance coverage. Optional coverage is available for property damage claims. Under Alberta law a fault-based system is used to determine which individuals contributed to an accident. Auto insurance covers the driver, occupants and potentially any pedestrians or cyclists involved in a collision with the vehicle. The Alberta government requires drivers to carry third-party liability coverage for any losses they might cause others to suffer. Every insured person has access to medical payments through their own auto insurance policy, commonly known as Section B coverage.

##### *Access & Information*

Injured parties should contact their insurance company immediately following an accident in order to determine what coverage might be available. If any at-fault person was insured at the time of the accident, the injured party must seek compensation from that person and their insurance company. The accident must have been another person’s fault in order to sue for damages. Injured parties have an obligation to get as much information as possible at the accident scene and are expected to take reasonable steps to lessen the effects of injuries through medical treatment. There is an expectation that injured parties will seek medical assessment within 10 business days of the accident, and must follow the full treatment plan. Injured parties have two years from the date of the accident to file a lawsuit, and having done so, are expected to take material steps within a three-year period to arrive at a decision, or face the possibility that their case might be dropped by the Courts.

##### *Coverage*

The current limit of coverage for no-fault Section B accident benefits is $50,000, and lasts for two years from the date of the accident. There is currently a $$4,956, limit (adjusted to inflation) on the amount an injured party can claim for pain and suffering if they sustained only minor injuries (sprain/strain or whiplash). A person can access twelve (12) weeks of therapy for this type of injury, without referral from a physician or insurance company approval. Treatments are pre-approved and care providers directly bill insurance companies, with specified dollar limits for each treatment modality (e.g., chiropractic ($750 per person). The limit on pain and suffering does not limit an injured party’s ability to claim for other economic losses, such as loss of income.

If an injured party’s medical insurance coverage is exhausted and a lawsuit commenced, they may be able to apply to the defendant’s insurance company for payment of ongoing expenses, including economic losses. Income replacement losses are based on net rather than gross income. Disability income benefits are calculated at 80% of net weekly wages to a maximum of $400 weekly, up to 104 weeks for total disability. No payments are made for the first seven days of disability. Unemployed persons eighteen years of age or older receive $135 weekly for up to 26 weeks.

If the defendant was uninsured and all of the Section B coverage is exhausted, injured parties can apply to the Motor Vehicle Accident Claims Program (MVAC) for reimbursement of interim medical expenses. Information regarding claiming personal injury damages is provided through the MVAC Program guide [See: <https://open.alberta.ca/dataset/d87026bf-7b6c-4b80-b21d-db332bd39e6d/resource/d108b783-3ffd-49b0-998c-f3260cc53843/download/2016-alberta-motor-vehicle-accident-claims-program-information-resource.pdf>].

**Alberta Motor Vehicle Accident Claims Program**

The Alberta Motor Vehicle Accident Claims Program, the payer of last resort, is governed by the Alberta Motor Vehicle Claims Act, and does not cover damage to the vehicle or contents, any insurance deductible or loss of use. Injuries claimed through this program must result from a MVA that occurred in Alberta, and the accident must be the fault of another person, who was uninsured at the time of the accident. In the case of uninsured at-fault vehicles, injured parties must commence a lawsuit in an Alberta court against those who could be liable for the accident. In terms of benefits, the monetary limit of the MVAC Program is $200,000 for all claims arising out of any one accident; if injuries are serious enough to exceed this limit, injured persons may be entitled to additional compensation from their own insurance company. Any compensation paid by MVAC for medical costs are deduced from any final settlement in a personal injury claim. The process of claiming for damages in excess of $25,000 includes a decision as to which court to sue in (Provincial Court or the Court of Queen’s Bench). If the claim is in excess of $50,000 injured parties are required to sue in the Court of Queen’s Bench.

The work disabled participant from Alberta interviewed as part of the research, who had suffered catastrophic injuries in a MVA (blind and paraplegic), received a total lifetime benefit of $100,000 through the MVAC program. He learned about the program and was assisted to apply by an advocate at the Spinal Cord Injury Association in the city in which he lives. He was completely at fault for the accident and apparently could not claim any accident benefits through his motor vehicle insurance. He has used this benefit to renovate his home and purchase mobility and other aids.

### **4. Employer-Sponsored Long-term Disability Benefits (LTD) (BC & AB unionized nurses and teachers)**

[Note: A comparative table describing access, eligibility criteria and coverage for BCNU members on LTD and for nurses who are Alberta Public Service Commission employees on LTDI benefits appears in Appendix F: Long Term Disability/Nurses].

Also called “private long-term disability plans,” LTD plans were “established to fill the gap left by [relatively low paying] C/QPP-D, Workers’ Compensation and auto insurance” (Roeher, 1992, p. 6). A bias exists in this system “toward coverage for higher income earners such as management employees, public sector unionized workers, and employees in large manufacturing operations” (p. 6), who work for larger companies, or in a position that provides employer-paid benefit packages. Relatively generous benefits are provided “for a much broader range of disabilities” (p. 6), but primarily for those with disabling illnesses.

Employer-sponsored long-term disability (LTD) benefit programs, included in public sector unionized collective agreements, provide income set at a percentage of earnings at the time of disablement for nurses and teachers unable to perform the duties of their occupation due to disabling illness or non-occupational injury. Employers (or the BCTF in BC) contract with private insurance corporations to adjudicate claims medically and to make long-term disability benefit payments. Typically, employer-sponsored programs include both short- and long-term disability benefits, with claimants required to exhaust sick leave, EI illness and short-term disability benefits before becoming eligible for LTD benefits.

#### **a) Disabled nurses in BC**

##### *Eligibility*

Nurses in BC who are members of the British Columbia Nurses’ Union (BCNU) and who become disabled as a result of non-work-related injury or illness are eligible to apply for LTD and/or the Enhanced Disability Management Program (EDMP) if they meet the following eligibility criteria:

i) are regular part- or full-time employees of B.C. health authorities (health employers), covered by the Provincial Collective Agreement (PCA);

 ii) have completed a three (3) month employment probationary period;

 iii) are continually unable to perform essential job duties during the qualifying period;

 iv) are eligible for the Employee Disability Management Program (EDMP), for those who are struggling and need support due to an occupational or non-occupational illness or injury.

LTD eligibility begins four (4) months after an employee becomes totally disabled due to non-occupational injury or illness (this qualifying period has been reduced over time from an initial period of 6 months). “Total disability” means the complete inability because of an accident or sickness, of a covered employee to perform the duties of their own occupation for the first two years of disability. Great West Life, which adjudicates claims medically makes long-term disability benefit payments, re-assesses all claims at the two-year mark. Thereafter, an employee who is able by reason of education, training, or experience to perform the duties of any gainful occupation for which the rate of pay equals or exceeds seventy percent (70%) of the current rate of pay for their regular occupation at the date of disability is no longer considered totally disabled. Total disabilities resulting from mental or nervous disorders are covered by the plan in the same manner as total disabilities resulting from non-work accidents or other illnesses. Employees who are eligible for benefits under the LTD Plan do not have their employment terminated. Following expiration of their sick leave credits and/or any other paid leaves to which they are entitled, they are placed on unpaid leave of absence until receipt of LTD benefits commences.

##### *Access & Information*

Information about LTD benefits can be found on the BCNU website [<https://www.bcnu.org/a-safe-workplace/illness-and-disability-services>]. The Provincial Collective Agreement (2019-2011) also provides details about the EDMP and LTD plans, and can be accessed via the BCNU website [https://www.bcnu.org/Contracts-Bargaining/Documents/REVISED\_2019-2022-nba-pca.pdf].

A nurse who meets the eligibility criteria for Long Term Disability can locate information about applying for benefits from the current Provincial Collective Agreement (available on the British Columbia Nurses’ Union website), and from their union steward or representative. Nurses wishing to apply for LTD Benefits should request a copy of the Healthcare Benefit Trust’s, “Your Long-Term Disability Claim Package," which includes LTD application forms, and general information about the program. Healthcare Benefit Trust provides disability benefits, and contracts the management, adjudication and payment of claims with Great-West Life. Applicants must see a physician and request they complete the physician section of the application form. The application form also includes a detailed section to be completed by the applicant asking about activities of daily living, current medications and treatments, tolerance for activity, information about hobbies and recreational pursuits, whether assistance is needed and what kind, and whether there has been improvement in condition. Those whose claims have been approved by the claims-paying agent, Great West Life, can access further information through the Group Benefit Plan and the Guide for Plan Members. When applying for LTD benefits, nurses have forty-five (45) days after the end of the four (4) month qualification period to forward their application to GWL or forty-five (45) days from the termination of any WorkSafe BC benefits. During the qualifying period, nurses applying for LTD benefits should determine if they qualify for any other sources of income, such as sick leave benefits, vacation pay, banked overtime, EI Sickness Benefits, ICBC wage loss benefits, or WorkSafe BC wage loss benefits.

##### *Coverage*

LTD benefits are indexed, taxable and calculated at 70% of the first $5,843 of the pre-disability monthly earnings, and 50% of the pre-disability monthly earnings above $5,843 or 66.6% of pre-disability monthly earnings, whichever is more. In the event that the LTD benefit falls below the amount set out above for the job that the claimant was in at the time of commencement of receipt of benefits, LTD benefits will be adjusted prospectively to seventy-percent (70%) of the first $5,843 of the current monthly earnings, and 50% on the current monthly earnings above $5,843 or sixty-six and two-thirds percent 66.6% of current monthly earnings, whichever is more based on the wage rate in effect following review by Healthcare Benefit Trust and/or the underwriter every 4 years.

Indexing begins after a person has been on claim for four years plus the four-month qualifying period. The benefit is adjusted to reflect the current wage rate for the job held on the date of disability, and is based on the same formula used to calculate the original entitlement. During the waiting period and the first two years on claim, a disabled nurse’s position is held for them. After the two year period, their “own occupation” ends and the position is posted. The nurse with the disability remains an employee with rights to return to work in an equivalent position using seniority rights under their collective agreement.

The cost of extended benefit premiums during the period of long term disability is borne by the employee and employer 50:50, and is taxable. Other premiums are waived (Group Life Insurance, LTD). Employees continue to accrue years of pensionable service while on an approved LTD plan. Employees on LTD are required to apply for CPP-D benefits; the LTD benefit is offset by the initial CPP-D benefit amount, not including the indexed portion of the CPP-D benefit. The LTD benefit payment is made so long as an employee remains totally disabled and ceases on the date the employee reaches age 65, recovers, dies, or is eligible for and begins receiving the Early Retirement Incentive Benefit (“ERIB”), whichever occurs first.

Rehabilitative employment refers to any occupation or employment for wages or profit or any course or training that entitles the disabled employee to an allowance, provided this rehabilitative employment has the approval of the employee’s doctor and the underwriter of the LTD Plan. If a disabled nurse is likely to return to work in some capacity, rehabilitation is offered by Vocational Rehabilitation Consultants employed by the Healthcare Benefit Trust (HBT). They offer a range of services such as work-hardening and back care programs, psychological support and counselling, vocational evaluation and assessment, retraining, job exploration and development, and assistance with return to work programs and rehabilitative employment. Any work undertaken during a return to work must be approved as part of an Approved Rehabilitation Plan (ARP), developed with the rehab consultant. Return to work can be part of an Early Safe Return to Work program (requires a written ARP) or Rehabilitative Employment (reduced hours, also requires an ARP). An employee who returns to employment under an ARP will receive all monthly rehabilitation earnings plus a monthly Long Term Disability benefit up to the amount set out earlier, provided that the total of such income does not exceed one hundred percent (100%) of the current rate of pay for their regular occupation at the date of the disability.

As part of their Illness and Disability Services, BCNU offers an Enhanced Disability Management Program (EDMP) that includes an holistic case management plan (CMP) based on an assessment of prognosis, capabilities and limitations, skill and education, and the likelihood of a return to work. The CMP is intended to provide early, appropriate and ongoing support for ill or injured employees. Regular employees who are off work with a work-related illness/injury, or who are off work for a non-work-related illness/injury for five consecutive shifts are required to participate in the Program unless the employee has a bona fide reason to decline. EDMP participants receive regular reviews and monitoring. Support is provided for those returning to work or transitioning onto Long Term Disability (LTD) benefits.

#### **b) Disabled nurses in Alberta**

We present information from the Alberta Public Service Commission (PSC) website about their employee LTD plan as it is applicable to the work disabled nurse that participated in our interview on their work disability experiences. This work disabled nurse had been working as a Nurse Therapist in community health clinics in Alberta as part of a region-wide multidisciplinary team encompassing three communities some distance apart. Her employer was Alberta Health Services (Ministry) and she was not a member of the union United Nurses of Alberta

Information is not presented on the United Nurses of Alberta (UNA) LTD plan, although this LTD plan is applicable to many nurses working in health care in Alberta.

##### *Eligibility*

Eligibility for PSC LTDI (Long Term Disability Income) depends on having been employed by the Alberta Public Service in a permanent position for at least three (3) consecutive months after being hired (there are also different employment eligibility criteria for those who are temporarily employed). Disability means a medical condition that causes an employee to be unable:

i) to perform any combination of duties which, prior to the commencement of illness or injury, regularly took at least sixty-percent (60%) of the employee’s time at work to complete, or

ii) to be gainfully employed.

“Gainfully employed” is defined as employment that an employee is medically fit to perform, for which the employee has at least the minimum qualifications and that provides a salary of at least sixty-percent (60%) of the employee’s pre-disability salary.

There is a pre-existing condition clause, as follows: Benefits will not be paid for any medically documented injury or illness for which the employee received medical services, supplies or any medical treatment prescribed by a physician during the ninety (90) days immediately preceding the effective date of permanent or temporary employment. The Elimination Period (or waiting/qualifying period) is eighty (80) consecutive normal work days (including statutory holidays), or the number of hours of work, for a continuing illness equivalent to eight (80) normal work days, starting the day an employee stops work or partially stops work because of bodily injury or illness. If approved, LTDI benefits would normally be paid effective the 81st day. If an employee returns to work after an absence caused by a disability, is no longer receiving LTDI benefits, and is disabled as a result of the same or a related condition within six months after the date LTDI benefits terminate, the disability is considered to be continuous and another elimination period is not served.

Depending on the nature and severity of an employee’s condition, the adjudicator may require the employee to be under a specialist’s care. If substance abuse, including alcoholism and drug addiction contribute to the employee’s disability, the treatment program must include participation in a recognized substance withdrawal program. From the time of the initial LTDI submission, the adjudicator will assess if an employee should apply for CPP -D benefits. If deemed potentially eligible for CPP-D, an employee must apply for CPP-D disability benefits within twelve (12) months of being placed on the plan, and must provide proof of application to the plan administrator.

##### *Access and Information*

Information about the LTDI plan and application forms are available on the PSC Alberta website: <http://www.psc.alberta.ca/Practitioners/?file=benefits/ltdi-continuance/titlepage&cf=409>

The insurance carrier is Great West Life (GWL). Completed forms (by the employee and attending physician) are sent to GWL Disability Management Services in Edmonton via mail, fax or email. An Employer’s Statement is completed by the applicant’s Ministry (in this case Alberta Health Services), including information about weekly earnings, the nature of the work and date of coverage. An adjudicator at GWL, who is an independent third party, assesses the claim, determines if the claimant qualifies for benefits and how long they can receive benefits. A case manager at GWL is assigned to the claim and contacts the claimant to obtain information about duties of their job, education and employment history, and medical history as it relates to the claimant’s current condition.

##### *Coverage*

The LTDI [benefit amount](http://www.psc.alberta.ca/Practitioners/?notoc&file=legreg/ltdi/amount-of-benefit&cf=409) is calculated at 70% of the employee's pre-disability salary, with no maximum bi-weekly amount. LTDI benefits are reduced by the basic amount of CPP-D, if applied for successfully. If an adjudication decision extends beyond the end of the elimination period, the LTDI Plan provides for the continuation of 70% normal salary to a maximum of two (2) months, or to the date of the plan adjudicator's decision, whichever comes first.

The LTDI plan offers vocational rehabilitation services intended to assist employees to plan and prepare for a return to work. The objective of rehabilitation is to assist the employee to return to work through a structured program. A rehabilitation program may be established for a specific period of time not exceeding 24 months. An employee who has been in receipt of LTDI benefits for 24 months or longer and is determined fit to return to their own or similar duties, will be eligible to receive benefits for up to 3 months from the date of determination, or the date of return to work, whichever comes first. Coverage under group benefit plans continues while employees remain eligible for LTDI benefits. These plans include: Alberta government employees’ group life insurance plan, prescription drug plan, extended medical benefits plan, dental plan, and health spending account. The employee’s Ministry makes both the employer and employee contributions to public service pension plans on behalf of employees receiving LTDI benefits. LTDI premiums are waived while receiving benefits, as are union dues.

#### **c) BC Teachers’ Federation Salary Indemnity Plan (SIP)**

The BCTF Salary Indemnity Plan (SIP) is an employee-pay disability plan. This means that the plan is solely funded by BCTF member contributions. The BCTF Salary Indemnity Plan (BCTF SIP) contracts the Great-West Life Assurance Company (GWL) to adjudicate claims medically and to make long-term disability benefit payments. GWL has been given the responsibility for the assessment of entitlement to benefits. The costs of the benefits are paid by the BCTF SIP, though the payments are issued by GWL. SIP benefits are not taxable because it is a self-insured plan. Members on SIP receive full pensionable and contributory service credit for the portion of time for which they receive benefits. SIP does not cover (medical/extended health/dental/life insurance) benefits. A member applying for SIP is encouraged to consult with their school district or local union office to inquire about maintaining these benefits. In some cases, the school district will continue to cost-share the benefit premiums for a period of time. SIP does not pay CPP and EI premiums. A member, in receipt of disability benefits, is not employed by the SIP. Therefore, CPP contributory time is not credited and disability benefits are not considered insurable earnings under the EI mandate.

##### *Eligibility*

The SIP provides both short- and long-term benefits to teachers who, due to illness or injury, are disabled from performing the expected duty of their job. If the illness or injury is work-related, a WCB claim must be initiated. The Plan applies to all active BCTF members with regular assignments. For the purposes of this section of the plan "disability" means either a physical or mental illness or injury. The SIP defines disability depending on the length of time the disability continues. There are two definitions of disability in the SIP long-term plan: one for the first 12 months of benefits, the “Own Occupation” period, and after that for the “Any Occupation” period. During the “Own Occupation” period, SIP defines “disability” according to normal employment duties and the amount of time a teacher spends performing those duties. To qualify for benefits a claimant must continually for a period of up to (twelve) 12 months commencing at the expiration of the qualifying period, be suffering from a disability that prevents the claimant from performing his/her normal employment duties. Those applying for long-term benefits must have been employed with a school district at least 20 days, exclusive of sick leave, and must exhaust all sick leave and short-term disability benefits (120 days maximum). A teacher who becomes disabled through injury or illness shall be eligible for benefits immediately following the termination of sick leave benefits.

##### *Access & Information*

Information about the LTD plan is available from the Salary Indemnity Plan Long-Term Pamphlet available online at: <http://www.bctf.ca/uploadedFiles/Public/SalaryBenefits/SIP/SIP-LongTermPamphlet.pdf>

When applying, the applicant must submit the following forms required by the plan administrator, specifically:

 i) a claimant application form signed by the member;

 ii) a medical form signed by a licensed physician, nurse practitioner, or registered

 midwife, or in special circumstances, a notarized statement signed by the member; and iii) the school board verification of sick leave form signed by an official of the

 employing school board, or local association or the BCTF.

After three (3) months of receiving benefits claimants are required to provide supporting medical documentation indicating that they are receiving ongoing care and treatment by a licensed specialist physician for the disability (the BCTF website specifies this kind of healthcare practitioner), or a registered psychologist as directed by a licensed physician, except where the plan administrator is aware that the disability is terminal. Receipt of benefits for an illness that is caused by drug or alcohol abuse shall be contingent upon the claimant’s enrolment and ongoing participation in a substance withdrawal program recognized by an addiction medicine specialist. If disability prevents a teacher from working for six months or longer, and if s/he anticipates a long illness, s/he must apply for Canada Pension Plan Disability benefits. After 12 months those on SIP benefits must provide proof of acceptance or denial of Canada Pension Plan benefits. CPP-D benefits do not reduce the SIP long- term disability benefits.

##### *Coverage*

BCTF SIP long-term disability benefits are payable monthly at month end, including July and August, and are non-taxable. Benefits are based on gross annual salary applicable on the last day of work or sick leave. The gross annual salary applicable on the last day of work or sick leave is adjusted due to salary increases negotiated retroactively. The benefit is calculated as

 • 65% of the first $40,000 of salary

 • 50% of the next $40,000 of salary

 • 40% of the balance of salary

Accommodation Employment is defined as receiving long-term benefits while working or volunteering. This may include working part-time, reducing a claimant’s assignment to accommodate disability, self-employment, volunteering, or participating in a work-

hardening plan with the BCTF SIP Health and Wellness Program. If applying for long-term benefits and involved in any of these activities, claimants must complete an Accommodation Employment Application. This application must be completed and signed by the claimant and physician. If receiving long term benefits and considering initiating part-time work, self employment, or volunteering, claimants must seek prior approval from the BCTF SIP with an Accommodation Employment Application. If a teacher is unable to return to work because of disability-related barriers, the BCTF SIP may provide a Rehabilitation Consultant to assist him/her. The Rehabilitation Consultant works with the teacher, his/her family, and health care providers to restore or improve health and functional capacity.

We interviewed a work disabled B.C. teacher and a principal for the current study. The LTD benefit for the principal was administered through the BC Principals’ and Vice-Principals’ Association Benefits Plan. Principals or vice-principals with questions about their benefits program are instructed to contact the Benefits Administrator at the school district in which they employed. The principal we interviewed informed us the benefit was structured similar to the BCTF SIP. Principals and vice-principals applying for LTD benefits must complete the Disability Claim-Employee Statement and have the physician complete the Physician’s Statement. The Benefits Administrator completes the Employer’s Statement and forwards it to the insurer (Desjardins Insurance). These forms are available on a secure site for plan members. The application should be submitted forty-five (45) to sixty (60) days after the first day of disability. A claim specialist reviews the medical and claim information and determines eligibility for disability benefits.

For B.C. principals and vice-principals, an Elimination Period is required during which time of the claimant experiences continuous, total disability before commencing LTD benefits. Total disability means a state of incapacity resulting from an illness or accident that prevents the applicant from performing each and every essential duty of their regular occupation. The Elimination Period is 117 calendar days, or expiration of benefits under the employer's sick leave plan to a maximum of 120 sick leave days, whichever is later. After the Elimination Period and a succeeding 60 months, total disability is redefined as: A state of incapacity, resulting from an illness or accident that prevents claimants from working in any occupation for which they are suited by education, training and experience. Whether or not any such gainful occupation is available in the area where a claimant resides does not affect entitlement to disability benefits. The benefit income is calculated at 60% of the first $7,500 of gross monthly earnings and 50% of the balance, up to a maximum of $10,000. Claimants are expected to be under the continuing care of a physician while receiving LTD benefits. The LTD Benefit is non-taxable, indexed yearly in accordance with the COLA, and is offset by the basic CPP-D amount (if a claimant applies successfully for CPP-D). LTD benefits proceed until age 65 or 35 years of pensionable service (less the Elimination Period), or retirement, whichever is earlier.

#### **d) Alberta School Employee Benefit Plan (ASEBP)**

ASEBP’s Extended Disability Benefits (EDB) plan is considered a “total disability” plan. If an employee is unable to perform normal duties due to illness or injury, ASEBP's EDB plan provides income replacement and ensures they receive appropriate treatment during the recovery process if their claim is approved. As part of EDB coverage, ASEBP's Health & Disability Management Services team works with the employee and the appropriate health care providers to design individualized plans to assist the employee through their treatment, recovery, and return to work. If the disability precludes a return to work, ASEBP will assist in quality of life issues.

##### *Eligibility*

For purposes of determining whether or not an employee qualifies for EDB, “total disability” means that:

 • during the first 90 days of injury or illness (referred to as the 90-day elimination period), the employee is totally and continuously unable to perform the duties of their normal occupation;

 • until the earlier of August 31 or January 31, during the 24 months following the 90-day elimination period, an employee continues to be totally and continuously unable to perform the duties of their normal occupation resulting in a loss of 30% or more in pre-disability earnings;

 • after 24 months of disability, the employee is unable to perform the duties of any occupation for which they are, or may become, suited through education, training, or experience which provides him/her with an income of at least 60% of pre-disability earnings.

To be eligible for Extended Disability Benefits, an employee must have EDB coverage and meet the definition of total disability at the time of the illness or injury. An employee is not eligible for Extended Disability Benefits if at the time of the illness or injury s/he did not have enough hours worked, discontinued benefits during a leave of absence, or if s/he has a [pre-existing condition](https://www.asebp.ab.ca/redirect.aspx?EC=HLEVEL&EN=Benefit+Guide+(EDB)+-+General+Limitations). In addition, to be eligible for an ASEBP benefits plan, an employee must fulfill these specific requirements:

 • s/he must have completed one day of service and be working in the regular and active service of his/her employer;

 • s/he must be working a minimum number of regular hours that is equivalent to at least a 0.2 Full-Time Equivalent (FTE). Some employers may have adopted a higher number of minimum work hours or have a specified waiting period in accordance with the collective agreement or management policies;

 • s/he must be covered under a provincial health care insurance plan;

 • s/he must be under the age of 65 years: and

 • s/he must be a resident of Canada

##### *Access and Information*

[Information from ASEBP website: <https://www.asebp.ab.ca/docdisplay.html?EntityCode=HLEVEL_2&EntityKey=5624> ]

Disability benefits become payable after a ninety-day elimination period. The elimination period is defined as the time from the start of total disability to the 90th consecutive calendar day of total and continuous disability. The start of total disability is the date of accident, injury or medical incident and is usually the day after the last day worked. However, if an employee is on a regular scheduled school break (i.e., July/August, Christmas, or spring break) then the start of the elimination period will be the date they become totally disabled (not the day they were scheduled to return to work). If an employee believes that they may be away from work due to an injury or an illness for more than ninety (90) days, they should inform their employer as soon as possible. Their employer initiates a claim for EDB with ASEBP on their behalf.

As soon as ASEBP is advised of the pending claim, the employee will be contacted by an EDB Intake Facilitator. The EDB Intake Facilitator starts the application process as early as possible to ensure a smooth transition from workplace sick leave benefits to EDB, and will continue as the primary contact throughout the application process. The EDB Intake Facilitator forwards an application package to the employee. The package includes information about disability coverage, a brochure called Applying for Extended Disability Benefits (EDB), and the following forms:

 • Employee Statement - to be completed by the applicant

 • Release of Information - to be completed by the applicant

 • Physician Statement - to be completed by a general practitioner

 • Medical Statement - to be completed by the appropriate treating specialist, recognized by the College of Physicians and Surgeons of Alberta

Employees are responsible for all costs incurred in obtaining medical reports for their claim application.

Claim information, along with all documentation supporting disability, must be submitted within 12 months from the end of the 90-day elimination period. If the information is not submitted within this time frame, the employee forfeits the right to apply for Extended Disability Benefits. The Intake Facilitator will present all the information submitted at an adjudication meeting with the service team within the Health & Disability Management Services Department. Following the adjudication meeting, if the claim is approved, the employee will be assigned a Claims Facilitator who will take the claim over from the Intake Facilitator and continue to look after the employee’s specific needs. The employee will work with their Claims Facilitator, employer, and health care providers to establish and develop their support, recovery, and return-to-work goals, as applicable.

##### *Coverage*

ASEBP offers two Extended Disability Benefits plans:

Plan D

 • 70% of basic monthly earnings, to a maximum benefit of $17,500 per month.

 • all other sources of income must be reported and may be deducted from the EDB payment.

 • the employer must pay all or part of the premiums, meaning that benefits payable under this plan are subject to income tax.

Plan E

 • 66 2/3% of the first $2,500 of basic monthly earnings plus 45% of any additional basic monthly earnings, to a maximum benefit of $11,792 per month.

 • all other sources of income must be reported and may be deducted from the EDB payment.

 • the employee must pay 100% of the premiums, meaning that benefits payable under this plan are not subject to income tax.

ASEBP disability benefits are reduced by the amount of the basic CPP-D benefit. If approved for EDB, the employee has the option to continue all benefits that were in place prior to the disability. ASEBP waives premiums for the following benefits:

 • Life Insurance;

 • Accidental Death & Dismemberment (AD&D);

 • Extended Disability Benefits;

 • Extended Health Care.

If the employee was participating in Dental Care or Vision Care coverage, s/he may continue these benefits; however, these premiums are not waived—there will be a charge for these benefits. The employee should check with the employer about who is responsible for payment of these premiums during disability.

Payment will not be made for any period of total disability during which the employee:

 • leaves the province or country without ASEBP's consent;

 • without ASEBP's consent, temporarily or permanently moves to or lives in a location where medical treatment or rehabilitation employment opportunities are not equivalent to the medical treatment or rehabilitation employment opportunities available to the employee prior to the move;

 • engages in any occupation or employment (including self-employment) for wage or profit, other than as part of a rehabilitation or accommodation employment program.

Rehabilitation employment is a temporary program to assist a disabled employee's progression to pre-disability employment. The program allows for light, modified, or alternate work or training during the period of rehabilitation and progressive return to a pre-disability level of employment. Rehabilitation employment must be pre-approved by ASEBP to ensure the proposed employment or training meets program objectives. Progress is reviewed on an ongoing basis. While performing rehabilitation employment the monthly EDB payment is reduced by 50% of any salary/earnings received.

Accommodation employment provides income protection to disabled employees who are unable to perform all the regular duties of their occupation because of a progressively-debilitating illness (e.g., multiple sclerosis). These employees may be able to continue working part time in a limited capacity. Accommodation employment must be supported by medical documentation and made within 30 days of the reduction of the employee’s normal FTE. While in accommodation employment, the monthly disability benefit is reduced by 50% of the earnings received from the employee’s school jurisdiction. If the sum of employment earnings and disability benefits exceed 100% of what the earnings would be if the employee was working full-time, disability benefits will be reduced by the excess amount.

ASEBP manages Extended Disability Benefits (EDB) claims through Health & Disability Management Services (HDMS). HDMS is a holistic approach to EDB claims management incorporating medical information with additional information gathered from a covered member’s specific situation—their home environment, their work environment, and any other factors that can contribute to overall well-being. Claims Facilitators meet face-to-face with covered members on EDB to provide support, gather information, and coordinate a win-win solution with all stakeholders including the employer (school jurisdiction), the employee representative (union or association), and health care professionals.

#  **Qualitative Interviews - Key Findings & Discussion**

In this section we present key findings from the work disabled participant interview data organized thematically. Each theme is illustrated with experiences of people’s pathways through various work disability systems, followed by an in-depth discussion of each theme arising from the interpretive analysis. These themes were revealed during in-depth analysis of the narratives created from each participant’s interview transcripts. The narratives are data rich, complex and provide a clear understanding of the pathways—and side trips—the disabled participants experienced as they sought to access work disability benefits. We chose not to break the narratives up; they convey not just individual experiences and how each participant understands these, but also cohere in ways that reveal the connections among the different accounts. The narratives can be found in the Appendices (Appendix F).

The themes identified during narrative analysis are as follows:

1. Correspondence between different providers and programs is minimal.
2. All work disabled participants experienced “informational troubles.”
3. Navigating bureaucratic mazes is stressful, and constitutes “work without choice” for work disabled individuals applying for benefits.
4. Doctors act as gatekeepers to supports, services and livelihood, not unproblematically.

## **1. Correspondence between different providers and programs is minimal**

Each program has specific, separate eligibility criteria, different pathways for applicants as they approach and move through systems, and the programs “do not cohere in any consistent way” (Torjman, 2017, p. 1).

The term “correspondence” is used here to refer to any connections, direct or otherwise between the different programs under study in each province. In the discussion below, we also include discussion of two federally-administered income support programs (CPP-D and EI Sickness Benefit), because they directly impact how the programs under study are administered.

Typically, various disability income support programs in Canada are considered to be part of the disability income support system, but as Sherri Torjman (2017) cautions, referring to these “disparate programs as ‘a system’ is an undeserved compliment” (p. 1), as our study reveals. A work disabled individual applies to a specific disability income support program depending on their situation at the time of illness or injury, and there is little, if any, correspondence between the programs and program providers under study. Both social assistance and provincial “last resort” benefits are available to those who have gaps in work disability coverage, or are denied coverage from other providers, but our research showed that no assistance, information or guidance about these programs was offered about these social assistance programs to those participants who experienced problems with coverage from other providers.

The one exception is a unique correspondence between BC PWD benefits and CPP-D. In BC, there is a legislative requirement for recipients to pursue other means of support. If the recipient meets the financial eligibility criteria for PWD, they are sent a CPP-D package by Ministry staff in the CPP Program Services team, and are required to submit it back to the Ministry of Social Development and Poverty Reduction. The Ministry requests that the package first be sent to them to ensure that the package is correctly signed and contains all the pages required for it to be accepted for adjudication by federal CPP-D workers. The package is forwarded on to Service Canada CPP-D processing office by courier to ensure the fastest delivery of the completed package. As there are legislated requirements for Ministry clients to pursue CPP-D, returning the package first to the Ministry allows the clients to continue to receive benefits unhindered by requests for follow-up for information related to submitting the CPP-D application package. The manager we interviewed from the B.C. Ministry also informed us that applicants to the BC PWD program who have already successfully applied to CPP-D, prior to applying for PWD benefits, are considered part of a “prescribed class,” i.e., the province recognizes them as CPP-D beneficiaries and brings them into the PWD program without the need for supplemental application to the province for disability benefits.

#### **Correspondence among benefit providers under study**

Of significance, from the provider websites, and the provider and participant interview data, we found that there is no evident referral or co-ordination processes across providers (other than the example above, and to disallow or reduce benefits if a recipient has successfully applied for more than one). For example, beneficiaries receiving LTD, BC PWD or Alberta AISH, ICBC or WorkSafeBC/WCB Alberta benefits are encouraged (and in some cases required) to apply for CPP-D benefits. However, little or no information or assistance to apply is made available by these program providers (other than that described above by the B.C. Ministry), nor are beneficiaries referred directly to CPP-D by other benefit programs. Also, those applying for benefits who exhaust their sick leave or EI Sickness Benefit before their application for disability benefits has been approved, can apply for provincial social assistance or disability benefits, but these programs’ stringent financial eligibility criteria often exclude applicants with assets, for example, professionals such as nurses and teachers. In addition, none of the work disabled participants who had significant gaps in coverage while waiting for approval from their primary provider knew of the option to apply for provincial disability income support or social assistance. In one case, a work disabled teacher secured a bank loan to meet expenses during a three-month gap in coverage, while waiting for an appeal decision of her initially-rejected application for BCTF LTD benefits.

#### **Correspondence with CPP-D**

Those who have applied successfully to the work disability benefit programs studied here were requested (and in most cases required) by their primary provider to also apply to CPP-D. CPP-D has become increasingly stringent in terms of eligibility criteria to the effect that in 2015 an estimated 57 % of applicants are rejected, with about 35% of these accepted upon reconsideration (Torjman, 2017). None of the participants in the current study who applied for CPP-D were provided with any information or assistance to do so by their primary disability benefit provider, despite the fact there is strong financial impetus for the provider in having claimants apply. Once a beneficiary applies successfully to CPP-D, their primary benefit is offset (reduced) by the CPP-D basic amount, a substantial cost savings for the primary provider. To their credit, one LTD provider informed a beneficiary that she would not be asked to apply for CPP-D until the provider was confident she could be successful. Unfortunately, that assistance was limited; at the point the provider required her to do so, her case manager did not provide any information or offer to help with the CPP-D application process.

For those participants who applied successfully for CPP-D, the process was considered daunting, and not all were successful initially. All agreed the offset, or reduction in primary benefit payment, is unnecessary and financially restrictive. One participant expressed it this way: “If the full CPP-D amount was allowed, it could cover extraordinary medical expenses not covered by my other provider. For example, dressings, bath chairs, grab bars, wheelchairs” (Alberta nurse on LTD). Retaining the full CPP-D benefit would be especially beneficial for those receiving provincial disability benefits (AISH or PWD), as their basic benefit leaves them living in poverty. One LTD participant, who had to apply to CPP-D a second time after initial denial expressed frustration: “Having to apply for CPP-D feels like doing the bureaucratic work of Great West Life without substantial benefit” (B.C. teacher on LTD). Although those with non-indexed pensions do benefit from the small yearly COLA indexing attached to CPP-D, this teacher already had a non-taxable, indexed LTD benefit as part of her employment contract with BCTF, so did not consider the CPP-D indexing to be a substantial financial advantage. Interestingly, the five participants who had applied successfully for CPP-D were either visibly disabled and/or were receiving employer-sponsored LTD benefits bargained for as part of union contracts. The four who apply for CPP-D but did not receive it lived with invisible disabilities.

#### **Correspondence with EI Sickness Benefits**

Typically, most disability income support programs require work disabled applicants to exhaust workplace sick leave, where applicable, and then apply for EI Sickness Benefits. The maximum EI Sickness Benefit period is fifteen weeks, which may be inadequate for those whose conditions are episodic, and/or those whose LTD benefit’s qualifying periods are longer than 4 months. This was the case for several participants, resulting in periods with no income before the disability benefit began. For those participants who did apply for EI Sickness Benefits and were either denied assistance, or the EI Sickness Benefit period was not long enough, none applied for social assistance or provincial disability benefits, citing lack of awareness of this course of action.

## **2. Informational troubles**

Despite quite detailed information on each provider’s website about eligibility criteria, all participants spoke about ‘informational troubles’ understanding procedures for accessing benefits, and coverage (See Appendices C-G for tables depicting these). This term refers to how confusing everything is, particularly at the beginning with regard to programs and application processes. As a result, participants also spoke of the need for assistance with navigating the processes and programs, especially given they were all dealing with unfamiliar and distressing health conditions. None reported that they had consulted their provider’s website for information.

### *Discussion*

Freund (1982) says informational troubles are related to “…uncertainty about information important to one’s security [that] creates physiological consequences in the individual, which may, in the long run, adversely affect the person’s health” (p. 118). All the participants recounted how confused and exhausted they were trying to determine what was needed to apply for benefits, while unwell and dealing with injury or emerging (and unfamiliar) illness. Most of the confusion related to not knowing (and not receiving clear information or direction from providers) about application processes, provider programs, and/or mixed messages about benefits. Many expressed considerable fear and increased stress during the application period, mostly due to not knowing what to expect, concern about whether they would be approved for benefits, and fears about loss of income.

Examples from the data abound. After experiencing a spinal cord injury at work, a WorkSafeBC participant began receiving Wage Loss Benefits, but was not provided with additional information about the criteria for the period of these benefits. She also did not know what the difference was between wage loss replacement and the permanent disability award, or how or when the latter was determined, and described being rebuffed when seeking answers from WorkSafeBC. Her wage loss benefits had been reduced substantially because she was not participating in a WorkSafeBC vocational rehab program, despite the fact that she was still in treatment, anticipating further spinal surgery, and returning to work of any kind was specifically contraindicated by her neurosurgeon. Later, she sought assistance from the BC Workers’ Advisory Office who were helpful to the extent they were able to inform her that her appeal for WorkSafeBC benefits would likely not be successful (although she did not experience this as helpful). It was this work disabled person’s impression that WorkSafeBC considered the assessment of their vocational rehabilitation consultant more seriously than the surgeon’s assessment and recommendations, or her own description of ongoing, debilitating symptoms. Even after her appeal was resolved she remained fearful and uncertain due to ongoing lack of information and perceived lack of support from WorkSafeBC.

The BC nurse on LTD used up all her sick leave and vacation benefits during the six-month qualifying period for LTD benefits [at the time—the qualifying period is now set at four months], but unexpectedly learned from her employer that during this time she was required to pay all of her monthly extended health and dental benefit premiums, including her LTD premiums, amounting to over $500 monthly. A BC principal with rapidly-advancing Multiple Sclerosis interviewed for the study also cited exposure to negative stories and information on social media and in community-based support groups with regards to income support programs. This information added to her stress during the application period, along with being unwell, isolated, and alone while dealing with the uncertainty about the process and her health. This participant also expressed difficulty with the LTD application form that she described as inappropriate for those with episodic, fluctuating conditions.

For those receiving LTD benefits (teachers and nurses), frequent reviews, often monthly, in the first year or two were stressful and exhausting. Yearly reviews thereafter raise the fear of losing supports along with surveillance— “looking over your shoulder constantly.” One LTD participant described the annual review as “scratching the scab off the wound.” All the LTD benefit programs include an eligibility criteria transition, usually around the two year mark, as the definition of disability shifts from inability to complete tasks related to a person’s “own occupation” to those related to “any occupation” commensurate with skills and education. Participants uniformly experience this period with heightened uncertainty and fear of losing benefits and having to return to work, despite being unable to do so.

For the most part, work disabled participants who were receiving LTD benefits as part of negotiated union contracts received more information from providers. For example, the BC nurse received a detailed information package from the Health Benefit Trust Early Intervention Program. She was also assigned an Ability Management Consultant (via phone) to help track access to services/supports and assist with early return to work, which was unfortunately interrupted by a secondary cancer diagnosis. When asked about this information and how helpful it was she was disappointed that no one had met with her in person to discuss her particular needs, or to help clarify the information she received. It is also noteworthy that unionized work disabled participants live with substantial financial advantages compared to those receiving provincial “last resort” disability benefits.

Given these informational troubles, most participants sought whatever help they could, especially during the application process. Assistance came in various forms. Participants mentioned life skills workers (to help with cognitive difficulty post-concussion), church members, community health workers, nurse-advocates, community non-profit workers (at disability resource centres), lawyers, and union stewards. Union staff and stewards were not uniformly helpful. A BC teacher on LTD was appreciative of her union’s disability representative’s advice to be careful of providing information beyond what is asked for on any application or annual review form. The WorkSafe participant was ill-served by her union, a large national organization that vacillated between helping her and refusing to help. The Alberta Teachers Association Sick Leave and Extended Disability Benefit Guide exhorts teachers to proceed with caution regarding specific aspects of the process of applying for disability benefits, and appears to read the employer with suspicion.

Most participants spoke forcefully about the need for assistance during the application process for benefits, for example, a teacher suggested that she would have benefited from the help of someone uniquely familiar with the application process and dealing with insurance companies. She recommended that her union should have a representative with direct experience of applying for and receiving benefits. Others expressed the importance of having a guide/advocate during this process, mostly given how isolated they were feeling having to complete forms on their own, which was very stressful at the beginning when sick and uncertain about what is going to happen. One other concern expressed by participants, especially those with mental health impairments was that income support program applications require a negative way of looking at self with regards to limitations, in ways that exacerbate depression. Along with this, completing forms force applicants to deal with the reality of what life looks like (not great) when they are trying to focus on treatment during a confusing and uncertain time health-wise.

## **3. Navigating bureaucratic mazes: Work without choice**

This finding is closely linked to the previous one, but reveals a somewhat different set of experiences. Despite the fact that application processes and eligibility criteria are depicted on provider websites as straightforward, all participants experienced complicated and stressful bureaucratic encounters with disability income support providers, while not being entirely well-positioned to do so, creating unanticipated extra work not of their choosing. Several participants experienced these processes as markedly complicated and adversarial, prolonging the process of establishing benefits, and creating significant financial and emotional difficulties.

### *Discussion*

Participants in this study expended an inordinate amount of time, effort and energy securing income support, or otherwise responding to disability benefit program requirements. Disability activists and scholars are familiar with this dynamic of expending already-depleted energy to secure benefits and supports that constitutes a kind of “work without choice” (Krogh & Johnson, 2006, p. 170), experienced by participants as demoralizing. This disability work is necessary to navigate programs, and to receive support from various systems, including health care and medical services, non-profit community-based agencies, and care for self. Unfortunately, this work is made more difficult because of bureaucratic mazes for beneficiaries get caught, in part due to being ill-informed about programs and processes, but also because of how programs are administered.

Each disability benefit provider has unique processes for applying for benefits and meeting eligibility criteria, some more complex than others. For example, those applying for provincial disability benefits in both provinces (AISH in Alberta and PWD in BC) must first demonstrate they meet the means-tested, stringent financial criteria for basic social assistance. If they fail to, then they must apply to meet the separate, more generous means-tested financial criteria for disability income support before they are eligible to complete the application that assesses the extent of their impairments. None of the other benefit programs under study are means-tested, and meeting eligibility criteria adds complexity and difficulty to the application process. For BC PWD applicants this includes having a 28-page form completed by the applicant, a physician and/or an assessor from one of several health care professions. Both participants in the study who sought provincial benefits had to navigate complex bureaucratic mazes while attempting to meet financial criteria. For example, in November 2018, the AISH participant was still awaiting a Tribunal judgment (regarding her January 2018 appeal of overpayment), which was a result of conflicting (and costly, to the applicant) decisions made historically by different AISH workers. It is her intention to seek the assistance of the provincial Ombudsman should all avenues of appeal fail, adding another layer of difficulty and bureaucracy to the process. Interestingly, through a Freedom of Information request she received a copy of her AISH file (since 2008), which comprises 891 pages containing significant errors and omissions.

Despite being administered by similar private insurers, or claims-paying agents, employer-sponsored long-term disability benefit programs for unionized workers differ according to the collective agreements that govern these programs. For example, the long-term disability benefit program for teachers in BC (Salary Indemnity Plan) are self-funded through the BCTF, and the benefit itself is non-taxable and subject to COLA; whereas for nurses, the benefit premiums are paid by the employer, the benefit is taxable, and not subject to annual COLA increases. Also, both benefits are calculated as percentages of salary at the time of disablement, but differ substantially in terms of the percentage. One aspect of both LTD programs that is stressful for both nurses and teachers is the “own occupation/any occupation” transition, typically after the first two years of disability. In this case, the eligibility criteria shift from a disability that prevents an employee from being able to perform the duties of their own occupation to being able, by reason of education, training or experience to perform the duties of any gainful occupation, where the pay rate equals or exceeds a substantial percentage of their rate of pay (for nurses seventy-percent) at the time of disablement.

WorkSafeBC and ICBC also have idiosyncratic processes for establishing eligibility, often described by participants as resulting in lengthy, drawn-out claims as they seek to meet eligibility requirements for different elements of these providers’ programs. For example, seriously injured ICBC claimants are advised to seek legal assistance with their claims, and are advised not to settle until their inability to work is well established, often at the two year (104 weeks) point post-injury. This can be a stressful, adversarial process fraught with uncertainty about the outcome, income, and involving medical evaluations (by ICBC specialists). As described above, WorkSafeBC has various benefit categories for injured workers and that a worker can be transitioned between benefits, often without notice or consultation with claimants. In this case, it meant the WorkSafeBC claimant we interviewed was engaged in a lengthy, messy, conflicted, confusing process, ultimately engaging in an appeal. To her great frustration, her claim at various points in time moved in multiple directions, including backwards, all the while requiring her to respond to moves made by WorkSafe BC, exacerbating the exhaustion she experiences living with significant impairments.

Most provider communication with recipients is done textually, either via hard copy or email; meeting with provider representatives in person is rare, and phone communication is irregular. The AISH participant requested all correspondence in hard copy because approval provided on the phone by one worker was denied by another, without explanation. Given participants’ stated gaps in information, they rely on providers to assist them with the application and other bureaucratic processes, but frequently experience obstacles, including unhelpful or judgmental staff, creating undue stress and mistrust.

The BC PWD recipient expressed concern when, after waiting for a month longer than expected, she had to repeatedly contact the Ministry via phone to enquire about the status of her application, including requesting to speak with a supervisor, who also gave her incorrect information. She had not received her letter of approval, despite being told numerous times it had been sent to her. Even though she had previously submitted financial documents when she applied for social assistance to begin with, once it was established that the letter actually had not been sent, the Ministry requested a repeat financial eligibility assessment (the Ministry had misplaced the original documents). This request required her to take copies of her utility bills and bank statements to the Ministry office, despite the fact that she had done so previously as part of her application process. Her sense of this experience was that people like herself with invisible disabilities were judged by Ministry workers as undeserving of effort, and that Ministry workers do not have to “cater to” applicants because the Ministry is not a private, for-profit service organization. Significantly, for her, successfully applying for PWD benefits verifies that she is actually disabled and not making it up.

This theme of unworthiness was repeated throughout the data, and left participants feeling like they were not to be trusted, as if they were somehow scamming the system. They expressed feelings of helplessness with respect to provider bureaucracies, and of not being in control of their lives or income. Also, the WorkSafeBC participant, whose claims process could be described as deeply problematic, believed strongly that workers are inclined to settle claims early and for less because they just want to end negative interactions with WorkSafeBC. The AISH participant also experienced setbacks related to the Ministry misconstruing her assets during a complicated, drawn-out custody and divorce court proceeding, despite initially informing her that these did not affect her eligibility status, only to only to inform her differently two years later and bill her $11,000 for “overpayment” of benefits. She blames a change in workers from one who clearly understood and accepted her temporary financial situation and was willing to waive any penalties, to one who did not understand and was inflexible. Her belief is that this Ministry worker’s primary focus was to "see how many people in the system she can disqualify.”

It is notable that these experiences reflect a key finding of Howse’s (2017) research of claimants in the Ontario workers’ compensation system that, “workers engage with the compensation system morally, framing their experience of claiming in terms of right and wrong, just and unjust, good and bad” and “their experience is characterized by mistrust, confrontation … feelings of dehumanization and judgement” (p. ii). Several participants expressed deep mistrust of the providers, citing providers’ primary concern with money. One participant expressed her belief that bureaucratic obstacles prevented people from continuing with applications or appeal process in this way: “If we make this hard enough we won’t have to give away our money.”

Rather than viewing the application (and other bureaucratic processes) as necessarily concerned with gathering pertinent claimant information to determine eligibility, participants saw repeated requests for information “as a strategy to deny claims or to frustrate claimants and encourage the abandonment of claims in order to reduce costs” (Howse, 2017, p. 48). Mistrust is also engendered when participants feel dehumanized by providers who they believe fail to take into account their individual needs. For example, the WorkSafeBC participant with a spinal cord injury was sent to a generic rehabilitation program with a private company whose services were contracted by WorkSafeBC. This program did not focus on the kind of spinal cord injury rehabilitation that she specifically requested and needed. She felt obligated to comply with the six-week program, despite knowing it was ineffective and unhelpful, for fear of compromising her claim. All the participants spoke about surveillance and heightened scrutiny by provider organizations, engendering fear and uncertainty, and felt exposed by having to provide very personal information to providers in order to secure benefits. These findings—fear, heightened scrutiny and uncertainty—support previous findings (Kimpson, 2015) from a study of BC PWD benefits, and previous research into the CPP-D program (Doe & Kimpson, 1999).

The BC nurse described her understanding of what constitutes success, despite feeling beleaguered by repeated bureaucratic processes, including responding to repeated requests for information. She said: "Success depends on applying multiple times for programs and benefits and knowing how processes work, being able to advocate on your own behalf, and knowing how and when to jump through hoops. For example, on the forms, describing activities of daily living clearly and linking these to the effects of injury is crucial.” At the outset, most of the participants we interviewed were unaware of this potentially successful approach, and struggled to find information or assistance with completing forms.

## **4. Physicians: “Gold ticket” gatekeepers**

All of the participants spoke of encounters with physicians, although not always favourably. However, one participant expressed a uniformly positive experience with his physician, recognizing the physician’s gatekeeping position as constituting a “gold ticket” to supports and services. Of particular note, one specialist completed an LTD application form for a BC teacher that participated in the current study that included information directed toward Great West Life about litigation if the teacher was denied benefits.

### *Discussion*

Access to benefits for each provider is overly-medicalized, requiring a certified medical professional, usually a licensed physician, to assess and verify applicants’ impairments. Although applicants are given the opportunity to describe their condition and its effects on ability to carry out activities of daily living and/or employment responsibilities, the physician information is critical and must align with the applicant’s narrative. If, for example, this is not the case, the BC Ministry adjudicating the application contacts the physician to verify information on the form, or elicit more details. In B.C, those applying for provincial PWD benefits are allowed to have the Physician’s section of the application form completed by a registered Nurse Practitioner. Applicants depend on physicians to convey on paper (initially) the extent of their impairments and how these preclude employment, or constitute disability. Not all application processes are focused on ability to work. For example, those applying for BC PWD benefits have to provide information about their “disability” and how it affects their ability to care for themselves, and whether they need assistance doing so, but no questions are asked about ability to engage in paid employment.

Problems with physicians (and their office staff) were cited frequently in the participant interviews. For example, the Alberta nurse on LTD discovered a change in her physician’s office policy regarding fees for completing forms. She had not been informed that the fee policy had changed to paying in advance, rather than being billed after the form was completed, and assumed that when she dropped the form off to her physician that she would receive a bill in the mail once the physician completed the form. This lapse in communication meant that her annual LTD review form did not get completed for three months. She learned her benefits were disallowed during that period, which included the time the form had not been attended to by her physician, and waiting for GWL to review the information. She had to go on Alberta social assistance once she discovered the error, until her LTD claim was reinstated.

Misdiagnosis was also a problem for two of the participants with serious injuries. In the case of the ICBC participant, the physician she saw initially misdiagnosed the severity of her brain injury. Also, her physician noted on her application form for PWD benefits that she had “improved slightly,” and because of this she was denied PWD benefits, despite needing considerable assistance with activities of daily living due to cognitive impairment. The WorkSafeBC participant living in a small town in northern BC faced challenges with numerous physicians at her local First Nations clinic initially, including not being believed by the first five physicians she saw (and not believing them in response), receiving potentially dangerous advice (“resume normal activities”), and misdiagnosis. Eventually, when she saw a specialist six weeks later at a regional centre, she was immediately medically transported (medevac’d) to Vancouver for disc replacement and fusion surgery.

Participants experience physicians as frustrating and challenging, and encounters with them stressful, with the potential to exacerbate illness. Two participants felt anxious placing their financial security in the hands of physicians, especially when they question whether physicians understand the severity of their conditions, the impact on their daily lives, and the information physicians include or exclude on forms. The BC nurse expressed frustration reading a specialist’s consult in which she did not recognize it as her own information. She also understood that part of her role was to coach physicians because she realized that they are unaware of her daily life with disability, which is information GWL requests on the annual review forms. She was also frustrated that her naturopath, who she sees on a regular basis, unlike her physician, is not certified to complete her LTD review forms.

## **Conclusion**

Individuals who become work disabled have significant challenges accessing and navigating complex disability benefit programs, often without assistance and necessary information, and that this experience is more complicated and difficult than documented procedures suggest. In addition, with little correspondence between programs and program providers, those seeking appropriate benefits must rely on whatever assistance they can find, often external to the provider to which they are applying. Physicians play a key role in access to and continuance of benefits, not always favourably. The narratives crafted from the interview data contain detailed descriptions of each individual’s pathway through the benefit system to which they applied, and appear in Appendix H. Also, practical applications derived from the interviews with both work disabled participants and benefit program providers appear below.

## **C. Interviews with Representatives from Benefit Program Providers**

A current employee in the BC Ministry of Social Development and Poverty Reduction and a former employee in the Claims Division at ICBC, and were both interviewed at length for the study. Both participants were purposefully selected based on their experience with access, eligibility and benefits processes and procedures and with administration experience/responsibilities. Please see Appendix B for a copy of the Interview Guide used for the interviews with these two representatives of benefit program provides (with some small adaptations based on each program). Both program providers verified our understandings of how eligibility and access work, and provided insight into some of the more problematic aspects of their programs, in part by reflecting on examples from the experiences of work disabled participants receiving benefits from their programs interviewed for the current study.

### **a) BC Ministry Provider Participant Interview**

The current employee from the BC Ministry of Social Development and Poverty Reduction works in the branch of the Ministry concerned with adjudicating applications for PWD benefits and administering the disability benefit program, including administering the health supplements and medical benefit programs for successful applicants.

The Ministry employee spoke first about the process of receiving hard-copy applications from all over the province via mail or in-person delivery. Approximately 1000 applications are received and scanned into the system per month. Once received, applications are scanned into a central case management system and become the responsibility of the Health Assistance Branch within the Ministry. Within this Branch, a team of adjudicators reviews the scanned copies of applications to triage them in terms of urgency for follow-up and adjudication. Urgent needs are usually palliative cases or individuals who are homeless. The Ministry employee verified our understanding that in order to be eligible for disability assistance, an applicant must be financially eligible for income assistance (welfare) but also conveyed the following challenges for adjudicators applying eligibility criteria using the application forms:

Does the information on the page convey for example that that person one, has an impairment? And then does that impairment directly and significantly restrict their ability to perform daily living activities? And like you said, it is complex. And I think one of the greatest challenges for that adjudicator is trying to make sense of that narrative across the application. And I think that’s –this is probably more opinion than something out of practice guidelines or anything like that – we often see conflicting information between the three parts. Whether that’s the client’s story, the physician’s notes, or the assessor’s story. And I think that’s probably challenging across disability programs. But when a client comes in they tell their narrative, the physician may be someone who’s only seen them once in a clinic on a given day and that person may present with – they may present differently on different days as well. And then trying to read the whole narrative, capture all the details and then make that judgement, that part is challenging for sure. So, I think that what often happens is – from my experience –is that, you know there isn’t enough understanding of what we’re looking for in terms of what’s in the legislation, so does the impairment restrict and to what extent? So, you will often see a physician just indicating an impairment but they won’t go into the narrative that ties into the client’s story or the assessor’s story. So that’s part of the challenge … understanding the challenge of that administrative piece and the burden that it puts on clients is something that we’re aware of and trying to minimize.

Adjudicators see a variety of responses on applications, including blank sections. In the opinion of the Ministry employee, while more information is always better, especially when the person has a complex health situation or episodic symptoms, blank sections should not preclude benefits, especially if the Physician and/or Assessor have provided a cohesive narrative. The Ministry employee verified our understanding that adjudicators have some discretion in reviewing applications as long as they apply the policy and legislation “fairly,” meaning that the applicant must still meet the eligibility criteria set out in the legislation.

In the situation where there is no narrative in the application or the narrative provides conflicting information across application sections, adjudicators will contact physicians for clarification. However, in the opinion of the Ministry employee, physicians are good at diagnosing impairment but not so good at creating a narrative about the effects of that impairment in a person’s everyday life, with significant implications for the acceptance or denial of benefits. When asked about what kind of policy guidelines adjudicators and other staff might follow, they replied:

as a central agency making decisions for across the province, one of our focuses is that consistent reliable service and so you know, staff where they have challenging cases, they do case consults and make sure that they are on the same page. So that helps with consistency. From a process perspective the goal is that regardless of which individual picks up the application, the outcome will be the same, right? So, you wouldn’t want somebody denying in one case where the same set of facts is presented in another case, those should be consistent. So that also is the focus of that group and they work hard to ensure that they are consistent in their application of legislation of policy.

When asked about policy regarding attending post-secondary education while on benefits (in direct response to conflicting information from data in the current study and a previous study of BC PWD by the principal investigator), the Ministry employee stated that persons receiving PWD benefits are able to attend school full time without penalty. They also added:

if someone were to be approved for the disability designation, so that’s that PWD status that we talk about, that status is with them for life. So, the designation is separate from the eligibility for assistance payments on a monthly basis. So, if that person left assistance, went back to school, sought other employment, fell into hardship, then they could come back to disability assistance and that designation would not need to be reapplied for in the future. So, that’s what we call, in our case, MSO or medical services only, where someone has been designated with the disability status, has left for employment, but they retain access to that suite of health benefits that are provided to clients. So that acts as – I think that often times when clients do leave or they are no longer needing that monthly support cheque, it’s those health benefits that keep them on assistance and so that flexibility allows them to go and acquire employment and still get access to things like having their wheelchair repaired or replaced, or some of those really expensive benefits that perhaps that employer may not have coverage f

Once a person is approved for benefits, along with the approval letter, the person also receives communication about the products and services available to them, and are instructed to contact the Ministry for support to access those services and programs. When asked about means of access to Ministry workers, the Ministry employee replied, as follows:

They could choose to receive service in a face-to-face environment, over the phone, we also have our My Self-Serve tool, and then often times on the health side – so like in the medical equipment world for example – they may approach their physician who’s going to link them up with a community OT for an assessment and they would work with that OT to gather the equipment that they need, and often that OT works as a liaison really in that role to acquire that equipment for them as well … so if somebody requires a wheelchair they would apply, the request would need to be pre-approved by the Ministry and then the product would be provided by, for the most part, a contracted service provider [with the Ministry].

The Ministry employee also verified our understanding of the services that were available to PWD beyond income support, including transportation for those living in rural areas to medical centres, for example. They confirmed that each service or supplement has separate eligibility criteria and processes for accessing them.

When asked about return to work, the Ministry employee mentioned that there is no requirement to work for those with the PWD Designation, but clients do have access to employment programs and services should they seek to return to work. The Ministry employee also spoke about the relatively new annualized earnings exemption (AE) [previously earnings exemptions were calculated on a monthly basis, considered a disincentive to work full-time] in terms of benefitting PWD with episodic conditions:

There are a number of disabled clients that do work and that is promoted and so access to programs like that annualized earning exemption makes work more, I think more accessible. I think things like that AE allow people to balance work with their chronic health conditions. So, if someone has –as we often see with chronic health –kind of cyclical symptoms … so allowing someone to work full-time in the months that they’re able to and not at all in others, so stuff like that, on the Ministry side it does allow that flexibility.

Those with the PWD Designation who wish to re-enter the workforce also must submit a monthly “stub” either in person or online that provides proof of earnings. Interestingly, a person could still be working and apply for PWD benefits. In this case, the Ministry looks at the employment income (to determine financial eligibility), not the fact that a person is working or not.

When asked about room for improvement in the benefit provider program, the Ministry employee replied:

There isn’t a transition across provinces for assistance. So that probably to me is one of the gaps that we see. And that comes up – I mean statistically not that frequently – but it comes up enough and we talk about it enough that I think that’s a gap for folks and especially when we look at the reality of our economy and the portability of jobs across provinces and you know years ago we saw – and even know –people living on Vancouver Island who were commuting to the oil patch to work in Alberta and where do they have their doctor, is it in BC or is it in Alberta? And vice versa, when we see oil and jobs decrease in Alberta, those people come back to BC and maybe in a border town, maybe Kootenays, they may have closer access to services in Alberta and we don’t have reciprocity of that disability designation across provinces. So that comes up for us and that would be nice to see a similar sharing of decisions I guess, or designation

When prompted for additional clarification of portability of benefits and additional challenges in the benefits program, the Ministry employee added:

Yeah, between provinces, yeah. That’s a gap for sure. That’s really the biggest one. I think we do also coordinate with the Indigenous Services Canada group when individuals are moving on and off reserve and so that designation is seen as the same between us and that group and so that’s very similar to that prescribed class group where affiliation is seen as one and the same.

In terms of other barriers to services or in the process chain … yeah, I’m not sure. I guess some of the things are obvious to me about being around for so long – are we going to see an online application form? Hopefully we will in the future. I don’t know where that is but that could be seen as a barrier for some, not having that flexibility … it seems like a simple thing on the surface but it is incredibly complicated. Your research kind of points to the challenges around the coordination that that type of thing would require and you know, it would need to be done very well. Also, there could be a better coordination of benefits across public sector entities [WCB and ICBC] and I think – much like your research – every entity or Ministry has their own focus right?

When presented with information from the participant interviews, the Ministry employee recognizes the challenges people face:

It’s a struggle for our staff to hear that people are having a hard time applying and the perception that they’re part of the problem, so I’m happy to sort of look at getting some more feedback on what are our challenges and what are they seeing because really, at the end of the day we want this process to be better and easier for people because … everybody in this Ministry is here to help people and not to create barriers and make it harder. So, I think at times people get frustrated and they say, oh the government’s worried about their money and how much they’re spending and all sorts of stuff and in this work that couldn’t be further from the truth really. It’s about supporting people who are really in need.

### **b) ICBC Provider Participant Interview**

A former ICBC employee spoke at length about how claims for serious injury (e.g., brain injury) have been handled historically, and how recent changes (2014) were designed to more effectively manage benefits, in particular recovery and care benefits. ICBC now uses occupational therapists (OT) to oversee the management of the recovery and care aspects of a claim, whereas historically this oversight was done by senior examiners who could be “highly technical on the tort claim,” but not so experienced with accident benefits management. In the opinion of the former ICBC employee, this change meant that medical experts and examiners were “much more apt to follow the recommendations of the OT.” Occupational therapists are hired on contract to manage recovery and care for claims. However, some occupational therapists do not become involved in the claim until well after the injury. The former ICBC employee indicated that ICBC had been working towards implementing 24-hour notification for people with catastrophic injuries (e.g., brain injury or loss of limb), reflecting the context of the following statement: “We’re there as a company to support the person who’s injured, but it’s also to understand, do they have any specific needs? Do we need to provide some immediate counselling and trauma discussions so they be better prepared to deal with it?”

In addition to the occupational therapist role described above to oversee the management of a claim, ICBC also assigns a recovery team, consisting of physicians and rehabilitation coordinators and/or occupational therapists, to understand the health care and recovery needs of the injured person and to devise their care plan, with the costs of medical services covered by ICBC. Interestingly, in this new management model (borne out in our participant data), occupational therapists are now the de facto ICBC representatives on personal injury claims. When an injured person retains a lawyer to manage the legal aspects of their claim, ICBC adjusters are precluded from any further dialogue directly with the injured party; all further discussion with the adjuster proceeds through the lawyer. The injured party and the lawyer communicate with the OT about treatment and rehabilitation services. According to the former ICBC employee, the focus of the OT “is primarily to ensure that the accident benefits and the medical treatments are applied appropriately, lawyers are much more likely to talk to them or our rehab coordinator.”

The former ICBC employee verified information on the ICBC website about when ICBC benefits begin after an accident as follows:

…you have to be totally disabled from your work for 7 days. You receive benefits on the 8th day. So, the moment you call in a claim through our dial-a-claim or online, you’re already qualified for the benefits, you don’t have to reapply at 8 days. The benefits just kick in on the 8th day. Then you receive – and in the interim the rules tell you, the legislation says, that you should be applying for employment insurance so that you can claim disability benefits [EI Sickness Benefits] if you’re entitled to disability benefits that is, through the EI program. And then once the 15 weeks are over, which is technically the 16 weeks because you had to wait, then ICBC jumps back in and provides you with your benefits.

Having said this, the former ICBC employee points to a challenge experienced by claimants with respect to an EI claim, when asked at what point an injured party learns they have to apply for EI Sickness Benefits:

Usually at that first appointment, but I’m going to tell you, that’s what the legislation reads, we push our adjusters away from making that recommendation [requiring claimants to apply for EI Sickness Benefits] because it’s more hassle than it’s worth - if EI worked the same way we did where you call it in and you’re entitled [it would be more expedient/helpful than it is]. If you apply for EI the day you report your accident to ICBC, you will not receive EI benefits probably for the next two to six weeks. It’s just not a good system. So, we said, that’s putting the customer in harm’s way. So, what we decided to do because we’d have to reimburse it anyway, let’s just pay it, let’s just do what’s right for the customer; so it’s rare that you would get a recommendation to go to EI today. We would just manage the benefits for you and we would qualify what you’re entitled to within that first week. So, we’d ask for your employment information. We’d try to confirm that information so that by the 8th day you at least qualify and we know how much we’re going to have to pay you.

When the former ICBC employee was informed that the young woman interviewed for the current study, who had sustained a brain injury in a MVA accident, was receiving a small wage loss replacement twice yearly, he was surprised and stated:

….the legislation says we have to pay monthly –what we would do is we would try and send a cheque every two weeks. Most people are paid every two weeks and to me you don’t walk away from that obligation. I think it’s completely inappropriate that someone is being paid two times a year. That’s ludicrous. I think if they were working regularly then every two weeks they’d get whatever pay cheque they were entitled to for being off work.

When it was suggested to the former ICBC employee that the young woman in question was worried about losing her wage loss benefits at the 104-week transition period, they replied:

After 104 weeks there’s a secondary 104 weeks. The determination of the qualifications for the second 104 weeks is that you have to be totally disabled from any job. So that’s a difficult hurdle for someone who’s still cognitively functioning. But if she still believes that she’s totally disabled, her lawyer should have recommended that she apply for disability benefits [CPP-D and/or PWD, which she did unsuccessfully].

The former ICBC employee was asked a few questions about how the aforementioned woman’s ICBC claim and her benefit experience. The former employee provided a detailed response of a hypothetical and creative solution that would support her substantially in terms of recovering enough to work, and supporting a return-to-work transition. In doing so, the former employee suggested that most of the people managing these claims are perhaps not as creative as they could be and manage claims by rote, following the same course of action they have always done, basically following the legislation to the letter. Interestingly, the former employee also says that the adjusters managing such claims have a certain amount of discretion, but their managers may not want to engage in creative solutions, so the solutions do not get advanced. In fact, those with inflexible managers often do not bother bringing creative solutions forward for approval and summarized it further as follows:

It’s easy to adjust claims; it’s difficult to adjust people. You have to understand what motivates the individual [claimant]. And in order to understand that, you need to know the individual, you need to know their case, and when you have a formula you really don’t learn about how can you more effectively negotiate resolution ‘cause you know nothing about the person because everything’s been by rote.

The former ICBC employee spoke at length about changes that ought to be made to ICBC “to more effectively get people better”. In particular:

It’s not just about giving people benefits, it’s about making sure that the benefits are leading to an objective and that is recovery to the best functional capacity you can. If you have someone with a severe brain injury, or if they’re a quadriplegic, that doesn’t mean you give up on trying to get them to be functional on whatever residual function they’re left with. That’s kind of the obligation. You can’t bring them back to 100% but can I bring them back to 60%, that’s what an insurance company – like the one I came from [ICBC] – needs to be doing. That should be their mandate. And in order to do that you have to hire the appropriate professionals to oversee that. So now that they’re moving into a care model, their hiring has changed so that they’re bringing on people, OTs, retired nurses, people from SFU’s disability management program – so they’ve become much more inclusive in who they want to hire because it’s no longer negotiating a claim for people, it’s helping them through their recovery.

When asked about what happens when pathways unfold in unintended ways, the former ICBC employee stated that antagonistic relationships can develop when a disability lasts longer than would be anticipated for the type of injury, or when an independent medical examiner provides an opinion that the claimant should be returning to work but has not. Typically, the adjuster who is handling this kind of situation, and who has handled a number of similar claims, begins to wonder what might be wrong with the individual. Antagonism can also exist between a lawyer representing a claimant and the ICBC medical specialist, because the lawyer may also hire a medical specialist with an opinion opposite to that of the ICBC medical specialist. Unfortunately, the claimant is caught in the middle, and may not have access to supportive care to improve the prognosis in the interim. ICBC pays for the claimant’s medical assessments under “disbursements” claimed by the claimant’s, which can be a substantial cost. Claimants with tort claims exit the process when the case is settled. Typically those who sustain injuries without recourse to a tort claim take substantially less time to recover than those who seek damages through a tort process.

The former ICBC employee offered specific recommendations for change. While employed with ICBC, the former employee engaged in trying to change the culture so that there is a focus on recovery during the first 104 weeks, and believes that treatment is dependent on the medical community taking a more proactive role to include, but move beyond, basic treatment modalities (i.e., physio only); and to evolve the approach to treatment when a client is not recovering. Unfortunately, in their view, most physicians, especially general practitioners, have a limited amount of time and expertise in this rehabilitation area, and typically do not lobby for more advanced treatment or take a more active role communicating the rehabilitation needs of their clients. When prompted, the former ICBC employee confessed that ICBC is not entirely as effective as they could be helping claimants who have serious injuries that do not improve within typical or average time periods. The former employee suggested that rather than waiting two years (104 weeks) for the claimant to plateau, that claimants continually have a goal to strive towards within this window of time, and that the adjuster and/or the rehabilitation coordinator serve as a motivator or life coach to help the claimant recognize what they have achieved at different points in time on their trajectory and what can be done going forward from these points in time. The former employee also suggested that ICBC could ensure claimants have working computers, so that they could Skype with their rehabilitation coordinators in order to reduce the social isolation of living with a disabling injury. In their opinion, this would be an innovative way to provide a broader service to claimants as part of a renewed focus for ICBC and a part of effective disability management and care.

#  **Practical Applications**

## **a) Advocacy**

Developing ways to assist applicants to navigate various benefit systems is imperative given the challenges and difficulty each work disabled participant described with regards to navigating disability income support programs, especially at a very stressful time of sudden change in their lives due to ill health or injury. Part of the difficulty with navigation has to do with not receiving clear information or direction from providers about application processes, provider programs, and/or mixed messages about benefits. Even those with detailed information packages, typically unionized workers on LTD, could benefit from meeting in person with either a designated union member, ideally with personal experience of navigating systems.

Although tools such as online or hard copy guides might be a practical response to the navigational difficulty, having an advocate assigned to each applicant, or a guide to the relevant system, would be helpful and welcomed by applicants, who are living with considerable stress and uncertainty. Understanding how to complete forms, and basic advice about what to focus on and include are key to applying successfully for LTD benefits.

For those who receive provincial benefits, there are individual advocates available in the community to assist with applications, if applicants know where to find them. Although not canvassed as part of this research, anecdotally, these advocates struggle to meet demands for assistance with applying for provincial benefits. Also, people in rural settings in both provinces may need to rely on advocacy groups located in larger, urban centres, typically via phone or Skype. A list of advocacy groups who assist with applying for benefits would be an improvement upon the current situation. This list could be made available for all those who typically assist work disabled people in a variety of ways, including community health workers, members of spiritual communities, nurses, community non-profits, lawyers, occupational and physio therapists, and even union stewards.

For work disabled individuals who receive workers’ compensation or ICBC benefits, these providers are structured to support work disabled individuals through the process, given a primary focus on improving functional capacity in anticipation of a return to work. Although this kind of support is built into these programs, for example, through either a case manager/OT or rehabilitation consultant, work disabled people can feel pressured to return to work, and unsure how to respond. Again, a third party or independent advocate with knowledge of systems to inform them of choices and guide individuals through these processes would be beneficial, especially when the illness trajectory is not as expected, or bureaucratic barriers arise. Additionally, having advocates that provide advice and support not only within a system but across systems, who are familiar not just with a particular program, but with multiple programs would be helpful. These individuals would be familiar with each benefit program and when to draw upon one or another, and when one program can fill a gap in benefits.

## **b) Portability**

LTD benefit programs typically allow work disabled beneficiaries to live in other provinces, provided they are under the care of a physician and are adhering to their treatment plan. This is not the case for those who receive provincial benefits (AISH & PWD), who must remain in the province from which they receive benefits—their benefits are not portable and there is no reciprocity between provincially-administered disability benefit systems, although they can travel to other provinces with permission. Portability (or reciprocity) is especially important for those living in BC close to the Alberta border, for whom it is more convenient to access medical and other services in Calgary, for example, including specialist care.

Those receiving WCB-Alberta have what is called Right of Election (to claim under WCB-Alberta) if they normally live and work in Alberta but were injured on the job outside Alberta, or if they normally live outside Alberta, but were in injured while working in Alberta. A worker receiving WCB-Alberta benefits may leave the province for a short time if his/her doctor and WCB-Alberta confirm the trip will not delay recovery. If the worker moves out of Alberta, the wage replacement benefits will not change unless the move delays recovery and return to work. The worker must remain in regular contact with WCB-Alberta. From the online information we reviewed, it is unclear if WorkSafeBC has a similar portability clause, and we were unable to interview a representative to confirm portability criteria.

Given the policy that ICBC pays accident benefits to all occupants of vehicles licensed and insured in BC, and that any cyclist or pedestrian hit in Canada by a vehicle licensed and insured in BC is covered under accident benefits, we assume a kind of portability for those claiming and receiving ICBC Accident Benefits. We were unable to determine what kind of portability might be included in the ICBC benefit program.

# **Study strengths and limitations**

This study has two important strengths, as follows:

a) It provides in-depth detail about eligibility criteria, processes for accessing benefits, and coverage for four kinds of work disability income support programs. This detail is essential for understanding how these programs work in the lives of people with disabilities, and for recommending changes both at the program and system level.

b) It includes important qualitative data from work disabled individuals receiving benefits from various systems, in particular the experience of people with disabilities accessing and navigating these systems. It articulates the gaps and barriers within and between different income support systems through the experiences of work disabled individuals.

The limitations of the study are as follows:

We have an incomplete data set. We were unable to recruit a work disabled person receiving WCB-Alberta benefits, or an Alberta teacher on the ASEBP benefits. Our understandings of these programs is limited to publicly-available data, and we are unable to describe how a work disabled teacher or injured worker navigate either of these systems.

We also had difficulty, despite numerous attempts and strategies, to recruit representatives of disability benefit providers to verify our understandings of how programs function and to expand upon the program experiences described by persons with disabilities. This meant that we were unable to independently verify the information we compiled for programs other than for ICBC and Ministry of Health disability assistance. We were able to connect with many of the benefit providers but unfortunately, providers who initially volunteered to participate did not ultimately consent to do so, citing various reasons including limited availability of employees with the necessary expertise to participate in research. These providers declined participation at the point when they were sent the Interview Guide and Consent Form for review and signature.

# **Summary and Conclusions**

This research sought to better understand the delivery of work disability benefits in Alberta and British Columbia by documenting and mapping the provision of benefits and the experiences of individuals with work disability across different providers in both provinces. Going forward, the intention is to link it to similar mapping studies in other provinces conducted by researchers affiliated with the Centre for Research on Work Disability Policy.

The research was multi-phased, including: a) an online document review of access procedures, eligibility criteria and type of benefits/coverage for four kinds of work disability benefit providers in each province (workers’ compensation, driver/vehicle insurance, providers of employer LTD benefits, and provincially-administered disability assistance programs); b) in-depth qualitative interviews with work disabled recipients of each benefit programs; c) development of tables comparing similar systems in each province; and d) refinement of the tables based on interviews with (two) benefit program administrators.

We concluded that there is little if any correspondence between each of the providers under study, with notable but limited exceptions for correspondence with CPP-D and EI programs. Interviews with work disabled participants reveal that individuals who become work disabled have significant challenges accessing and navigating complex disability benefit programs, often without assistance, and that this experience is more complicated and difficult than documented procedures suggest. Work disabled participants experience serious information gaps making the application process challenging and difficult at a time of heightened uncertainty, and expended limited energy and resources working to navigate bureaucratic mazes. Also, the central (and equivocal) role of physicians in supporting applications and their effects in the lives of applicants was articulated.

The intent of the research was to identify areas amenable to policy changes that would improve the experiences of individuals with work disability in accessing and receiving benefits within the broader social safety net.

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# **Appendix A: Participant Interview Guide**

Questions to guide research interviews with disabled participants:

1. What prompted you to apply for disability benefits?
2. How did the application process go?
3. What kind of assistance, if any, did you receive with applying for benefits?
4. How long did the process take? Were there any significant events during the process?
5. What constraints or barriers did you experience, if any, during the application process or once you were approved for benefits?
6. How satisfied are you with the outcome? Are there unresolved issues, and if so, what are they?

# **Appendix B: Interview Guide for Providers**

(B.C. Ministry example, adapted for ICBC provider interview)

Preamble: We are interested in hearing from you given your experience developing, implementing and/or facilitating the use of disability policies and programs, and working with PWD about issues related to accessing benefits, meeting eligibility criteria, and determining coverage. We surmise that you likely have a different, possibly “bigger picture,” perspective than PWD applicants might have. In addition to eliciting your comments about to key findings that are emerging from our interviews with PWD, we will ask you about: your experience related to disability/income support policies and programs, and your perceptions of how PWD experience them; the disability policies and programs for PWD that you identify as being most relevant to applying for benefits and meeting eligibility criteria; your knowledge of how policies and programs are developed, put into practice, revised, discontinued; the strengths and benefits, problems and gaps of these policies and programs that you perceive for PWD, as well as experience yourself; and your ideas for improving/building on current supports and strengthening the system more broadly.

Provider’s role

Intro discussion about job responsibilities

a. How long have you been working in the disability system/with PWD? What is your primary role? What processes/activities are you responsible for?

b. What work do you do that involves PWD and/or the policies and programs that affect them?

c. Do you (or your staff) connect directly with PWD (via phone or computer, for example)? Or is all your contact textual (via forms and correspondence)?

d. What is the primary role of a case manager? Adjudicator? Other?

Description of application process and review of applications

a. What kinds of things are adjudicators looking for on application forms? From the physician, assessor and PWD (all three are able to make statements and provide information).

b. How do you apply policy re: eligibility criteria when decision-making about an applicant’s eligibility? Are there policy guidelines to assist with applying eligibility criteria to each case? How useful are these? Are there exceptions spelled out in policy guidelines? How well are these understood/applied? (e.g., attending post-secondary education while receiving benefits). Do you have any discretion re: applying criteria? Please describe or provide an example.

c. Could you describe the application process and/or how you apply policy re: eligibility criteria for a typical person with a chronic mental health or physical condition (here we might provide an example)? How do you determine which benefits they receive?

d. Do you connect/communicate with others working in the PWD (or other) system(s) about these policies and programs? What would be the nature/focus of these connections?

e. What kinds of things, either missing or inaccurate might work against an applicant?

f. What assistance, if any, does the Ministry offer to applicants during the application process.

Reflections on different aspects of the PWD program

a. What is your understanding of how well the PWD/benefit program works? What policies work well? From your perspective, where might there be room for improvement? If so, what kind of improvement would you recommend/suggest?

b. How are people connected with services offered as part of the benefit (beyond the basic benefit/shelter allowance?

c. How is transition to work or training for PWD managed and by whom?

d. What kind of latitude/flexibility do adjudicators and case managers have in terms of administering the PWD program?

e. What about intersections with other programs? What are the policies re: applying for EI illness benefit or CPP or social assistance? What kind of exemptions are there in terms of applying?

Problems encountered?

a. What happens when applicants don’t follow intended pathways?

b. What might be typical sticking points or places where the processes are either interrupted, stalled or create unintended barriers?

c. How do you make sense of apparent contradictions, e.g., applicants can’t be working at the time of application but can do so once on benefits?

d. When do you lose beneficiaries?

# **Appendix C: Provincially Administered Disability Benefits (BC PWD & AISH)**

|  |  |
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| Description  | Provincially-administered benefits provide income support for work disabled people who are without employment earnings, are ineligible for employment-based income support programs, including workers’ compensation, and those who are unable to rely on social networks for financial support. Provincial benefits are informally known as “last resort” benefits. Typically means tested, and not subject to income tax, provincial benefits provide financial assistance and other resources beyond welfare benefits.  |
|  | BC PWD Benefits (Disability Assistance) | AISH (Assured Income for the Severely Handicapped) |
| Eligibility | To be eligible for disability assistance, a person must meet the criteria for the Persons with Disabilities (PWD) designation and be designated as such by the ministry. PWD is not a permanent designation and the ministry has the authority to rescind an individual’s designation. Recipients retain the PWD designation whether or not they continue to be financially eligible for disability assistance. They are not required to apply for the designation upon reapplication for assistance. A Person with Disabilities (PWD) has reached 18 years of age and has a severe mental (including a mental disorder) or physical impairment that meets all of the following criteria:  • in the opinion of a medical practitioner or nurse practitioner, the impairment is likely to continue for at least two years • in the opinion of a prescribed professional, the impairment directly and significantly restricts the person’s ability to perform daily living activities either continuously or periodically for extended periods • as a result of those restrictions, the person requires an assistive device, the significant help or supervision of another person, or the services of an assistance animal to perform daily living activitiesThe ministry can designate someone as a Person with Disabilities (PWD), without going through the standard application process, if the person has already been approved for another prescribed government program or benefit, as follows: 1. People enrolled in BC PharmaCare Plan P (Palliative Care Benefits);2. People who have been determined by the Ministry of Children and Family Development to be eligible for the At Home Program – Medical Benefits and Respite (a program which assists family with the costs of caring for a severely disabled child);3. People who have been determined by Community Living British Columbia to be eligible to receive its support and services (Developmental Disability or Personal Supports Initiative); and 4. People determined as disabled by the Government of Canada and eligible for the Canada Pension Plan Disability Benefit.PWD status is effective the first of themonth following designation.Financial EligibilityApplicants and recipients of disability assistance are expected to use their assets for the purposes of personal independence if the value of the assets exceeds the specified exemption levels. Assets include any of the following:• cash• equity in property• equity in investments or other financial instruments• equity in trust where the applicant or recipient has control over disbursementsThe general asset exemption limits are:• $100,000 for a single, couple, or family where one person has the PWD designation• $200,000 for a couple where both adults have the PWD designationSome assets are allowed and don’t count towards the general limit above, such as:• A person’s home• One motor vehicle• Clothing and necessary household equipment• A Registered Disability Saving Plan• Assets held in a qualifying trust | Applicants must provide information about their severe handicap residency, age, income and assets. “Severe handicap” means an impairment of mental or physical functioning or both that, in a director’s opinion after considering any relevant medical or psychological reports, causes substantial limitation in the person’s ability to earn a livelihood and is likely to continue to affect that person permanently because no remedial therapy is available that would materially improve the person’s ability to earn a livelihood.AISH reviews relevant medical or psychological reports to determine if the criteria for severe handicap are met, that is, applicants and clients must have a permanent disability that severely impairs them physically or mentally to the extent they are substantially limited in their ability to earn a livelihood to support themselves financially. Applicants and clients are responsible for proving that a severe handicap exists and obtaining the appropriate documentation from a specialist physician. AISH considers whether training, rehabilitation or medical treatment will help clients to work enough to earn a living. Applicants must be 18 yrs of age, live in Alberta, is a Canadian citizen, not eligible for OAS, not in a correctional facility or some mental health facilities (e.g., Alberta Hospital, Edmonton). Also immigrants who landed under sponsorship within last 10 years (according to Record of Landing).Both applicant and spouse or partner must apply for all other income for which they may be eligible (e.g., CPP-D, EI or WCB benefits). Income is used to determine eligibility for the AISH program and the amount of living allowance or modified living allowance a client receives. AISH recognizes a mutual obligation of cohabiting partners to support each other. Therefore, the total net income of the applicant, client, and their cohabiting partner are considered in determining eligibility for AISH and level of benefits. There are several categories of income: fully exempt, partially exempt and non-exempt (deducted dollar for dollar from benefit, e.g., CPP-D benefits). For single persons the first $800 of income is exempt, and between $801 and $1500 is 50% exempt up to $1150 maximum exemption.AISH also uses assets of applicants and cohabiting partners to determine eligibility. Applicants, clients, and their cohabiting partner are required to declare their assets and provide appropriate documentation to substantiate the value of those assets. AISH classifies assets as either exempt (not counted) or non-exempt (counted). As a program eligibility requirement, the total value of all non-exempt assets owned by an applicant, client, and their cohabiting partner must not exceed $100,000.Status Indians residing on or off reserve may be eligible to receive benefits through the AISH program.Sponsored immigrants may apply for AISH if:* The sponsor is unable to provide necessary support;
* The sponsor has abandoned the sponsored immigrant and the sponsor’s location is unknown; or
* The sponsorship arrangement has broken down.
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| Access | Applicants need to be able to show that they have explored all possible income resources for which they may be eligible. E.g., WorkSafe BC, Canada Pension Plan, Student Financial Assistance, Old Age Security, or personal assets (cash-on-hand, or items that can be sold or converted into cash). Those who fail to accept or refuse to pursue other income, or other means of support, may be ineligible for assistance or eligible at a reduced rate.At the discretion of the Ministry, applicants may be required to participate in a specific employment-related program that, will assist the applicant or recipient to find employment, or become more employable.The application process includes:1. Demonstrating financial eligibility2. Completing the Persons with Disabilities Designation ApplicationApplicants [speak with a worker](http://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/access-services) [via phone or in person] to request an application, which has three sections: An applicant portion, [2 pgs to be completed by the applicant] A physician or nurse practitioner completes the medical report portion [5 pgs] A prescribed professional completes the assessor report portion. [a doctor, registered nurse or social worker—8 pgs focused on functional abilities]Ministry reviews the completed application and informs applicants whether or not they meet the eligibility criteria for the PWD designation. | Via AISH application form (on website) completed by hand or on computer, and submitted to the nearest AISH office. A short form is available for those diagnosed with terminal conditions or are in palliative care; for those with developmental disabilities; and, for those returning to AISH within 2 years of leaving the program for reasons other than a change in disability/condition). Applicants who are palliative are prioritized. AISH application form (on website) can be completed by hand or on computer, and submitted to the nearest AISH office. A short form is available for those diagnosed with terminal conditions or are in palliative care; for those with developmental disabilities; and, for those returning to AISH within 2 years of leaving the program for reasons other than a change in disability/condition). Applicants who are palliative are prioritized. The income and asset information is reviewed. If the applicant meets the residence, age, and financial eligibility criteria (see below) then AISH sends one or more medical reports for the health professional to complete. A letter of approval (or otherwise) will be sent, and benefits are backdated to the month AISH received all the complete information to approve the application. |
| Coverage | The amount of financial support depends on the size of the family, and whether another person in the family has the PWD designation. As of April 1, 2019, the monthly benefit amounts (including $375 monthly shelter allowance) are: Up to $1,183.42 for a single applicant Up to $2,073.06 with spouse also has the Persons with Disabilities designation Up to $1,609.08 if a single-parent family with two childrenRecipients who meet the Ministry of Health (MOH) residency requirements are provided with premium-free MOH medical coverage through Medical Services Plan, no-deductible PharmaCare, and low-cost annual bus pass through BC Bus Pass Program.Specified health supplements are provided to all recipients of disability assistance who meet the eligibility criteria for each supplement.BC requires applicants who potentially qualify for CPP-D to apply for it once provincial Disability Assistance is approved. If successful, BC provides the difference calculated between the CPP-D benefit and the provincial benefit, up to the provincial benefit total.Those with PWD designation can still work and earn money without changing the benefit up to a certain amount. The annual earnings exemption applies to money earned between January 1–December 31, with a new exemption limit beginning each year. The current exemption limits are: $12,000 for a single person with the Persons with Disabilities designation $14,400for a family with two adults where only one person has the Persons with Disabilities designation $24,000 for a family where both adults have the Persons with Disabilities designationThe annual earnings exemption can be used at any time during the year, and doesn’t affect the monthly assistance amount until more than the annual limit for that calendar year is earned. Any income over the annual earnings exemption limit will be deducted dollar for dollar from the assistance benefit. Beneficiaries can keep 100 per cent of the money earned, and receive a letter after earning 75 per cent of the exemption limit.Beneficiaries must complete a monthly income report if they: Earn income or have changes in family circumstances affecting the annual earnings exemption limit Income is money received from: • Working • Renting a room to another person, who also uses the same living space  • Someone who pays you room and board • Workers Compensation Board (WCB) temporary wage loss replacement payments • Pension plan contributions returned because contributions were insufficient Examples of changes in family circumstances include: • Joining or separating from a spouse • Moving • Adding or removing a dependentWorking PWD may be able to continue to get medical and transportation benefits, and won’t lose the PWD designation. The Monthly Report form should continue to be submitted each month, even when annual limit is reached in order to enable PWDs to receive disability assistance without having to reapply in the following circumstances: If earnings fall below disability assistance rates, and when eligible for a new earnings exemption limit in the new calendar year. | AISH provides a living allowance, personal benefits, health benefits and child benefits. The standard living allowance for those who rent or own a home, apartment or condo; live with family or friends; live in a private group home; or are homeless the max. is $1,588/mthly. Modified living allowance is designated for those living in an approved nursing home, auxiliary hospital or designated supportive living facility. It includes a personal needs amount of up to $315/mthly and private room ($1950) and standard room rates ($1601).Child benefits are $100/mthly for each dependent child.Health benefits (for applicant, spouse and dependent children) include prescription drugs from Alberta Drug Benefit List; some over the counter items and nutritional products. Also includes diabetic supplies, emergency ambulance trips, subsidy for Alberta Aids to Daily Living (AADL); basic dental work (check-ups, cleaning, x-rays, fillings), extraction, dentures, and other dental services; and optical benefits (q2yr eye exams + one pair of glasses for adults, every year for children).Personal benefits for specific needs over and above the monthly living allowance for applicant and dependent children, including addictions treatment; equipment maintenance for wheelchairs and scooters; health services such as acupuncture, chiropractic, massage therapy and physiotherapy; medical alert service; medical equipment not available through the AADL program or other sources such as private insurance or temporary equipment loan programs, e.g., orthotics, BP monitor, canes/crutches, heating pad; hearing aid batteries, CPAP & supplies, splints braces, etc.; medical supplies not available from the AADL program or other sources such as private insurance, home care or wound clinics; specialized clothing adapted for a disability; special diets; children’s benefits for help with infant and child care or children’s education; emergency benefits to help deal with an emergency situation beyond your control; escaping abuse benefits to help move and set up a new home; employment and training expenses; funeral benefits; moving benefits to set up a new home; travel benefits for health-related services, court attendance and training; food and routine veterinary services for an approved service animal. |

# **Appendix D: WCB Work Disability Programs**

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| Description  | Workers’ compensation is a social insurance program designed to protect labour force participants and their dependents against wage loss due to occupational injury or disease. Provincially based, administered by independent boards, typically funded through employee/employer premiums (although Alberta Workers’ Compensation is entirely funded by employers). (Roeher, 1992). Workers are eligible to receive benefits regardless of fault for injury. |
|  | WorkSafeBC | Alberta Workers’ Compensation |
| Eligibility | Not everyone is entitled to compensation under the Act, even if injured at work. To qualify for compensation, a person must be a "worker" employed by an employer covered by the Act. I n the case of injuries, compensation is limited to personal injuries arising out of and in the course of employment. The Board considers both medical and non-medical [employment-related] evidence to determine whether a worker’s injury arises out of and in the course of the employment. Two general categories of injury: personal injury (including psychological impairment) and occupational disease (e.g., cancer, respiratory conditions, contagious diseases). If the compensable injury, or the worker’s condition resulting from it resulted in further injury, increased disablement, disease or death then both the injury and resulting condition are considered compensable. In BC there is no definition of ‘disability” in the Act, but there must be loss of earnings as a result of disabling effects, not just impairment of function. Workers are considered disabled for the purpose of compensation on the date when they can no longer perform regular duties. | Two conditions: 1) injury must arise out of, and 2) occur in the course of employment. Covers all workers regardless of employment status (full/part time, temporary/casual). |
| Access | 1. Report the injury to employer as soon as practicable after the occurrence;
2. See a physician;
3. Report injury to WorkSafeBC [ a claim number is issued] using the Application for Compensation and Report of Injury or Occupational Disease.
 | Worker reports details of injury or occupational illness to employer as soon as possible. Employer legally required to notify WCB within 72 hours unless emergency medical treatment is needed or unable to do job beyond the day of the accident. Worker is required to inform physician or health care provider of work injury. Provider legally required to notify WCB within 48 hrs. Worker immediately completes and submits a report of injury form to WCB (online or fax). After notification of an accident/injury WCB gathers all relevant evidence and adjudicates the eligibility of the claim. |
| Coverage | Wage replacement benefits are non-taxable and indexed to the COLA minus 1% of annual change. Compensation differs according to the following sub-categories:• temporary total disability• temporary partial disability• permanent total disability• permanent partial disability• disfigurementSeveral types of compensation are provided:1. Compensation for loss of earnings caused by a temporary disability (90% of average net earnings up to Current Maximum Wage Rate—currently set at $81,9000);2. Permanent disability awards for actual or estimated loss of earnings, up until age 65; 3. Pensions to dependents for loss of support by a deceased worker;4. Health care benefits, including professional services, medications, structural modifications, medical supplies/equipment, some transportation costs, personal care expenses for severely disabled workers; 5. Rehabilitation assistance (a plan is developed for each eligible worker in collaboration with the worker, the employer and appropriate health care providers).If disabled previous to June 30, 2002 no deduction is made for CPP-D benefits. After that date the Board deducts benefits from permanent disability awards, using a formula reflecting the amount of CPP-D attributed to the compensable work injury. | Wage replacement benefits are non-taxable, start the next working day after injury, and calculated at 90% of net earnings, with a maximum insurable earnings amount set yearly by WCB. WCB coordinates and pays for necessary health services, which can be expedited to get care quickly. Most medical benefits are covered up front, some reimbursed to workers. Workers are encouraged to ask the employer and medical practitioner about modified work options while recovering. WCB assigns the claim to a case manager if time off work is required. Case manager helps develop a rehab and return to work plan, and informs worker of claim status. Alberta Health Care coverage costs are the worker’s responsibility. Note: there was no mention of clawback related to CPP-D on the publicly-available Alberta WCB website Medical coverageWCB coordinates and pays for necessary health care services. They will also expedite health care services where possible to help workers get necessary care quickly. Some examples of the kinds of services available include:* + - medical tests
		- doctor visits and reporting (they tell us about your injury and recovery by completing forms and reports)
		- physiotherapy and chiropractic appointments
		- hospital stays
		- prescriptions

Depending on the severity of the injury there maybe additional medical benefits available. The case manager can provide additional information regarding nursing care, attendant care, home modifications.* + Assistance while recovering from serious injuries (like surgery). If a worker is not able to perform household tasks because of serious injury, WCB will coordinate and pay for various services, including:
	+ Regular housecleaning and personal care tasks immediately following a serious injury or surgery if there is no one else in the home to assist with these activities (e.g., bathing assistance, food preparation, wound care, regular housekeeping).

Large housekeeping tasks inside the home (e.g., cleaning bathrooms, moving the fridge, washing walls and floors) —chores that will puts injured workers in an awkward position and are difficult to do.* + Large tasks outside the home (e.g., lawn care, cleaning eavestroughs, snow shovelling).

Longer-term personal care assistance. If a worker is severely injured and suffers from permanent impairment and needs help performing everyday tasks, WCB coordinates help based on needs, including:bankingbathing assistance bathroom assistancefood preparationwound careHome and car modifications. If a worker is severely injured and needs changes to his/her home or car, WCB coordinates and pays for this support.Travel and accommodations. If the injured worker needs to travel outside his/her city to receive medical care and rehabilitation services, WCB pays for and coordinates travel and accommodations. If the worker needs help after receiving treatment, WCB may also pay for a chaperone to accompany the worker. If this person loses time from work, a fee may be paid to them by WCB. Expenses may include:* mileage or transportation expenses
	+ meal allowance
	+ accommodations
	+ child care

Return to workWCB partners with the employee and employer to think of possible modified work options. Modified work can be: * Changes in job tasks or functions (e.g., less lifting or bending, changes in workload like hours worked per day or work schedule).
* Alterations to work area and environment (e.g., work in the office, shop or front counter), or the equipment used to perform job.
* Work that is normally performed by others.

If a worker’s injuries prevent him/her from returning to his/her job, the case manager talks to the worker about training and skills development opportunities. Services are based on the severity of the injury and the impact the injury/illness has had on the worker’s ability to return to the date-of-accident level of work and income. Services include:* Return-to-work skills profile is an assessment where WCB outlines, together with the worker, his/her current skills and abilities to help identify realistic employment options. This could include educational background, work history, interests, hobbies, and language ability.
* Resumé development /review helps workers learn to write a resumé that will stand out and help workers get selected for interviews.
* Career counselling to identify return-to-work options that match the worker’s abilities and are available in or near the community where the worker lives. This is a 25-day process where the employee works with a vocational specialist to determine job options based on education, experience, interests and skills. If the worker requires more support, WCB has custom supports that focus on the worker’s areas of need. WCB has specific coaching modules that focus on values and perceptions, how to move forward and build momentum in order to build confidence, communication, emotion and conflict management and goal setting. These modules help workers work through key elements needed for return-to-work success.
* Training-on-the-Job (TOJ) program is designed to help the worker get a new job when s/he cannot return to the pre-accident job. If the worker finds a job that requires onsite training, WCB shares the costs of training for the new position with the new employer. While in the TOJ program, workers receive their full salary and WCB reimburses the employer a percentage of the salary paid while they learn the new position.
* An academic assessment helps WCB determine if an educational program or long-term retraining is a good option for the injured worker.
* Job coaching is available if help is needed adjusting to a new job or returning to the previous job after an injury. It provides onsite support for both the worker and his/her employer to make sure s/he is successful in his/her return to work. This includes developing a gradual return-to-work plan, if needed.
* Supported job search helps the injured worker develop effective job search techniques and identify potential new employers. It also provides collaborative support before and after job interviews.
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# **Appendix E: Auto Insurance Accident Benefits**

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| Description  | “Beside workplace related accidents, road accidents are a major cause of physical disability. The auto insurance system is viewed as the main one of defense against the loss of capacity to earn as a result of injuries sustained in a road related accident” (Roeher, 1992, p. 4). |
|  | Insurance Corporation of BC (ICBC) | Alberta Auto Insurance (privately-administered)There is no general information provided by any Alberta automobile insurance brokers because each situation is different. However, the Insurance Bureau of Canada has some general information, and information specific to Alberta (and other provinces). Drivers are encouraged to shop around for the best coverage at the best price.If you own or drive a car in Alberta, by law, you must buy insurance coverage from a private insurer. A no-fault and tort-based system is used to set out accident benefits, and the right to sue in specified situations. ​Auto insurance covers the driver, occupants and potentially any pedestrians involved in a collision with the vehicle. The main user of the vehicle is referred to as the principal driver and any other listed drivers are referred to as occasional or additional drivers.  |
| Eligibility | Any driver, passenger pedestrian or cyclist who carries Basic Autoplan insurance from ICBC including Basic Underinsured Motorist Protection, and is injured or disabled as a result of a vehicle accident. ICBC pays accident benefits to all occupants of a vehicle licensed and insured in B.C. Accident benefits also apply if the person named on an owner’s certificate, or a member of their household, is hit by a vehicle while a pedestrian or cyclist. In addition, any cyclist or pedestrian hit in Canada by a vehicle licensed and insured in B.C. is covered under Accident Benefits.Regardless of fault accident victims may qualify for wage-loss assistance under their Basic Autoplan insurance. Wage loss benefits are available to an employed person who is unable to work because of a total disability caused by a motor vehicle crash. An employed person is defined as someone who had a job on the date of the crash, or someone who didn’t have a job on the date of the crash but who worked at least six of the 12 months preceding the disabling motor vehicle crash.Benefits are available only to people whose injuries have rendered them totally disabled for eight days or more. Eligibility begins on the eighth day of disability. | Those who own or drive a car in Alberta, by law, must purchase valid liability insurance coverage. Optional coverage is available for property damage claims. Under Alberta law a fault-based system is used to determine which individuals contributed to an accident. Auto insurance covers the driver, occupants and potentially any pedestrians or cyclists involved in a collision with the vehicle. The Alberta government requires drivers to carry third-party liability coverage for any losses they might cause others to suffer. Every insured person has access to medical payments through their own auto insurance policy, commonly known as Section B coverage.  |
| Access | Report accident to ICBC online or by phone. An ICBC adjuster investigates the accident and decides who caused it. The adjuster also reviews medical information and expenses. Before talking to ICBC some consult a lawyer who can report the claim to ICBC. If there is disagreement about ICBC decisions (about fault or damages), a lawyer should be consulted for advice, to consider whether or not suing the owner and driver of the other car for tort damages is the best course of action. Tort legal action must commence within 2 years from the accident date, or if receiving no-fault benefits, 2 years runs from the date of the last benefit payment.See a doctor as soon as possible to prescribe treatment. ICBC considers funding the cost of treatment.In most instances clients have two years from the date of loss to conclude personal injury claims, but limitation periods will vary depending on the type of claim and other circumstances.ICBC will typically offer money to settle or resolve claims. Normally personal injury claim should not be settled until the medical condition is stable and the MD can say when the injury will probably be resolved or if there will be any lasting effects. Claims are settled once ICBC offer is agreed upon. Once claims are settled, no further claims can be made, including if new effects from injuries arise. Claimants are required to sign a “full and final release of all claims” before receiving settlement money. | Contact private insurance company to determine what coverage might be available. If any at-fault person was insured at the time of the accident the injured party must seek compensation from that person and their insurance company. The accident must have been another person’s fault in order to sue for damages. Injured parties have an obligation to get as much information as possible at the accident scene and are expected to take reasonable steps to lessen the effects of injuries through medical treatment. There is an expectation that injured parties will seek medical assessment within 10 business days of the accident, and must follow the full treatment plan. Injured parties have two years from the date of the accident to file a lawsuit, and having done so, are expected to take material steps within a three year period to arrive at a decision, or face the possibility that their case might be dropped by the Courts.  |
| Coverage | Accident Benefits help with medical costs and wage loss if a driver is injured in a motor vehicle crash, regardless of who is at fault. ICBC pays accident benefits to all occupants of a vehicle licensed and insured in B.C. Accident benefits also apply if the person named on an owner’s certificate, or a member of his/her household, is hit by a vehicle while a pedestrian or cyclist. In addition, any cyclist or pedestrian hit in Canada by a vehicle licensed and insured in B.C. is covered under Accident Benefits.The amount paid under Accident Benefits is based on 75 per cent of the injured person’s average gross weekly earnings minus the weekly total of wage loss payments from other disability benefits, or $740 per week, whichever is less. No benefits are payable for the first seven days of total disability.An employed person may be eligible for up to 15 weeks of Employment Insurance (EI) sickness benefits when disabled by a motor vehicle crash. Anyone claiming wage loss benefits under Basic Accident Benefits should apply for EI benefits immediately. There is a two-week waiting period for EI benefits, during which wage loss benefits under Basic Accident Benefits can begin on the eighth day and cover the second week. Once EI sickness benefits begin, the EI amount will be deducted from any Accident Benefits entitlement.A homemaker who is substantially disabled in a motor vehicle crash and unable to perform most of his or her household tasks is eligible for benefits of up to $145 a week to hire a person to perform household tasks on the injured homemaker’s behalf. No benefits are payable when a family member performs the household tasks on the homemaker’s behalf and no benefits are payable for the first seven days of disability.Benefits are available for the duration of the disability, or until the disabled person reaches age 65, whichever comes first. However, after the first 104 weeks of payment, benefits are reduced by any benefits received from the Canada or Quebec Pension Plans.If the disabled person was employed or a homemaker at the time of the motor vehicle crash and turns 65 after the crash, he or she is also entitled to benefits for 104 weeks if the disability continues during that time. No benefits are payable beyond 104 weeks.If the disabled person is over 65 and employed or a homemaker at the time of the disabling motor vehicle crash, he or she is entitled to benefits for 104 weeks, if the disability continues during that time. No benefits are payable beyond 104 weeks.Accident Benefits provide reimbursement for reasonable and necessary expenses for medical and rehabilitation services to a limit of $150,000 for each insured person injured. This may include medical, dental, hospital, ambulance, chiropractic, physiotherapy or massage treatments, occupational therapy, speech therapy, prosthetics, medication, medical supplies or equipment, and attendant care.For serious injuries, requiring rehabilitation a team of professional rehab coordinators assist with recovery. One coordinator works with the injured/disabled person, his/her physician, in consultation with medical specialists and therapists, to design the best possible treatment plan. | The current limit of coverage for no-fault Section B accident benefits is $50,000, and lasts for two years from the date of the accident. There is a $4956 limit (adjusted to inflation) on the amount an injured party can claim for pain and suffering if they sustained only minor injuries (sprain/strain or whiplash). A person can access twelve (12) weeks of therapy for this type of injury, without referral from a physician or insurance company approval. Treatments are pre-approved and care providers directly bill insurance companies, with specified dollar limits for each treatment modality (e.g., chiropractic ($750 per person). The limit on pain and suffering does not limit an injured party’s ability to claim for other economic losses, such as loss of income.If an injured party’s medical insurance coverage is exhausted and a lawsuit commenced, they may be able to apply to the defendant’s insurance company for payment of ongoing expenses, including economic losses. Income replacement losses are based on net rather than gross income. Disability income benefits are calculated at 80% of net weekly wages to a maximum of $400 weekly, up to 104 weeks for total disability. No payments are made for the first seven days of disability. Unemployed persons eighteen (18) years or older receive $135 weekly for up to 26 weeks. If the defendant was uninsured and all of the Section B coverage is exhausted, injured parties can apply to the Motor Vehicle Accident Claims Program (MVAC) for reimbursement of interim medical expenses. Information regarding claiming personal injury damages is provided through the MVAC Program guide. The Alberta Motor Vehicle Accident Claims Program, the payer of last resort, is governed by the Alberta Motor Vehicle Claims Act, and does not cover damage to the vehicle or contents, any insurance deductible or loss of use. Injuries claimed through this program must result from a MVA that occurred in Alberta, and the accident must be the fault of another person, who was uninsured at the time of the accident. In the case of uninsured at-fault vehicles, injured parties must commence a lawsuit in an Alberta court against those who could be liable for the accident. In terms of benefits, the monetary limit of the MVAC Program is $200,000 for all claims arising out of any one accident; if injuries are serious enough to exceed this limit, injured persons may be entitled to additional compensation from their own insurance company. Any compensation paid by MVAC for medical costs are deduced from any final settlement in a personal injury claim. The process of claiming for damages in excess of $25,000 is very complicated and includes a decision as to which court to sue in (Provincial Court or the Court of Queen’s Bench). If the claim is in excess of $50,000 injured parties are required to sue in the Court of Queen’s Bench. |

# **Appendix F: Long Term Disability/Nurses**

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| Description  | Also called “private long-term disability plans,” LTD plans were “established to fill the gap left by [relatively low paying] C/QPP-D, Workers’ Compensation and auto insurance” (Roeher, 1992, p. 6). A bias exists in this system “toward coverage for higher income earners such as management employees, public sector unionized workers, and employees in large manufacturing operations” (p. 6). Relatively generous benefits are provided “for a much broader range of disabilities” (p. 6), but primarily for those with disabling illnesses. |
|  | British Columbia Nurses’ Union (BCNU) | Alberta Public Service Commission (PSC)(for nurses employed by Alberta Health Services) |
| Eligibility | Members who are eligible for Enhanced Disability Management Program (EDMP) & LTD are regular part and full time employees of Health Authorities who have completed a 3 month employment probationary period. Employees eligible for EDMP are those who are struggling and need support due to an occupational or non-occupational illness or injury. For LTD eligibility begins 4 months after employee becomes totally disabled due to injury or illness.“Total disability” means the complete inability because of an accident or sickness, including mental or nervous disorders, of a covered employee to perform the duties of their own occupation for the first two (2) years of disability. Thereafter, an employee who is able by reason of education, training, or experience to perform the duties of any gainful occupation for which the rate of pay equals or exceeds seventy percent (70%) of the current rate of pay for their regular occupation at the date of disability is no longer be considered totally disabled under the Plan. | Eligibility for PSC LTDI (Long Term Disability Income) depends on having been employed by the Alberta Public Service in a permanent position for at least three (3) consecutive months after being hired (there are also different employment eligibility criteria for those who are temporarily employed). Disability means a medical condition that causes an employee to be unable:i) to perform any combination of duties which, prior to the commencement of illness or injury, regularly took at least sixty-percent (60%) of the employee’s time at work to complete, orii) to be gainfully employed.“Gainfully employed” means employment that an employee is medically fit to perform, for which the employee has at least the minimum qualifications and that provides a salary of at least sixty-percent (60%) of the employee’s pre-disability salary.There is a pre-existing condition clause, as follows: Benefits will not be paid for any medically documented injury or illness for which the employee received medical services, supplies or any medical treatment prescribed by a physician during the ninety (90) days immediately preceding the effective date of permanent or temporary employment. The Elimination Period is eighty (80) consecutive normal work days (including statutory holidays), or the number of hours of work, for a continuing illness equivalent to eight (80) normal work days, starting the day an employee stops work or partially stops work because of bodily injury or illness. If approved, LTDI benefits would normally be paid effective the 81st day. If an employee returns to work after an absence caused by a disability, is no longer receiving LTDI benefits and is disabled as a result of the same or a related condition within six months after the date LTDI benefits terminate, the disability is considered to be continuous and another elimination period is not served.Depending on the nature and severity of an employee’s condition, the adjudicator may require the employee to be under a specialist’s care. If substance abuse, including alcoholism and drug addiction contribute to the employee’s disability, the treatment program must include participation in a recognized substance withdrawal program. From the time of the initial LTDI submission, the adjudicator will assess if an employee should apply for CPP -D benefits. If deemed potentially eligible for CPP-D, an employee must apply for CPP-D disability benefits within twelve (12) months of being placed on the plan and must provide proof of application to the plan administrator. |
| Access | Enhanced Disability Management Program—referral or self-referral (for nurses whose date of disability occurs on or after Apr 1, 2011): A written application is sent to the claims-paying agent/underwriter during a 4 month qualifying period while off work for total disability. It is completed and signed by the physician and the disabled employee. Applicants must be continually unable to perform their job's essential duties during the qualifying period. | Information about the LTDI plan and application forms are available on the PSC Alberta website: <http://www.psc.alberta.ca/Practitioners/?file=benefits/ltdi-continuance/titlepage&cf=409>The insurance carrier is Great West Life. Completed forms (by the employee and attending physician) are sent to GWL Disability Management Services in Edmonton via mail, fax or email. An Employer’s Statement is completed by the applicant’s Ministry (in this case Alberta Health Services), including information about weekly earnings, the nature of the work and date of coverage. An adjudicator at GWL, who is an independent third party, assesses the claim, determines if the claimant qualifies for benefits and how long they can receive benefits. A case manager at GWL is assigned to the claim and contacts the claimant to obtain information about duties of their job, education and employment history, and medical history as it relates to the claimant’s current condition.  |
| Coverage | Totally disabled employees shall receive a benefit equal to seventy percent (70%) of the first $5843 of the pre-disability monthly earnings and fifty percent (50%) on the pre-disability monthly earnings above $5843 or sixty-six and two-thirds percent (66-2/3%) of pre-disability monthly earnings, whichever is more. The $5843 level is increased annually by the increase in the weighted average wage rate for employees under the Provincial Collective Agreement for the purpose of determining the benefit amount for eligible employees as at their date of disability. It is understood that this adjustment will only be applied once for each eligible employee, i.e., at the date of the disability, to determine the benefit amount to be paid prospectively for the duration of entitlement to benefits under the LTD Plan. In the event that the LTD benefit falls below the amount set out above for the job that the claimant was in at the time of commencement of receipt of benefits, LTD benefits will be adjusted prospectively to seventy percent (70%) of the first $5843 of the current monthly earnings and fifty percent (50%) on the current monthly earnings above $5843 or sixty-six and two-thirds percent (66-2/3%) of current monthly earnings, whichever is more based on the wage rate in effect following review by HBT/underwriter every four years. [ostensibly indexing every four years]If other disability income is available to the employee, e.g., CPP-D or WCB they must apply for this income prior to receiving LTD benefits. In the event a totally disabled employee is entitled to any other income as a result of the same accident, sickness, mental or nervous disorder that caused them to be eligible to receive benefits from this Plan, the benefits from this LTD Plan are reduced by one hundred percent (100%) of such other disability income. Private or individual disability plan benefits of the disabled employee do not reduce the benefit from this Plan. The LTD benefit payment is made as long as an employee remains totally disabled and ceases on the date the employee reaches age sixty-five (65), recovers, dies, or is eligible for and begins receiving the Early Retirement Incentive Benefit (“ERIB”), whichever occurs first.Medical, Extended Health and Dental – Employees on long term disability who have already been granted unpaid leave of absence (including time while in receipt of LTD benefits) totaling up to twenty (20) days in any year may choose to continue to maintain any or all of the Medical, Extended Health and Dental benefit plan coverage. The premiums will be cost shared by the employer and employee on a 50-50 basis provided the employee pays their portion of the premium for such coverage in advance on a monthly basis.Pension – Employees on long term disability shall be considered employees for the purposes of pension in accordance with the Municipal or the Public Service Pension Plan Rules, as applicable.Group Life Insurance – Employees on long term disability shall have their group life insurance premiums waived and their coverage continued.Regular employees who are off work with a work-related or a non-work-related illness/injury for 5 consecutive shifts are required to participate in the Enhanced Disability Management Program (EDMP) unless the employee has a bona fide reason to decline. EDMP participants receive regular reviews and monitoring. Support is provided for those returning to work or transitioning onto Long Term Disability (LTD) benefits.   An Employee who returns to gainful rehabilitative employment under an Approved Rehabilitation Plan (ARP) will receive all monthly rehabilitation earnings plus a monthly Long Term Disability benefit up to theamount set out earlier provided that the total of such income does not exceed one hundred percent (100%) of the current rate of pay for their regular occupation at the date of the disability.An employee who returns to gainful rehabilitative employment under an ARP and works 15 hours or more per week will have their Medical, Dental, and Extended Health benefits reinstated. Group life insurance and LTD premiums are waived. An employee who returns to gainful rehabilitative employment under an ARP will have all other benefits accrue on a proportionate basis. Earnings received by an employee during a period of total disability that are derived from employment which has not been approved as rehabilitative employment under an ARP, reduces the regular monthly benefit from the Plan by one hundred percent (100%) of such earnings. | ​The LTDI [benefit amount](http://www.psc.alberta.ca/Practitioners/?notoc&file=legreg/ltdi/amount-of-benefit&cf=409) shall be 70% of the employee's pre-disability salary, with no maximum bi-weekly amount. LTDI Benefits are reduced by the basic amount of CPP-D, if applied for successfully. If an adjudication decision extends beyond the end of the elimination period, the LTDI Plan provides for the continuation of 70% normal salary to a maximum of two (2) months, or to the date of the plan adjudicator's decision, whichever comes first.The LTDI plan offers vocational rehabilitation services intended to assist employees to plan and prepare for a return to work. The objective of rehabilitation is to assist the employee to return to work through a structured program. A rehabilitation program may be established for a specific period of time not exceeding 24 months. An employee who has been in receipt of LTDI benefits for 24 months or longer and is determined fit to return to their own or similar duties, will be eligible to receive benefits for up to 3 months from the date of determination, or the date of return to work, whichever comes first. Coverage under group benefit plans continues while employees remain eligible for LTDI benefits. These plans include: Alberta government employees’ group life insurance plan, prescription drug plan, extended medical benefits plan, dental plan, and health spending account. The employee’s Ministry makes both the employer and employee contributions to public service pension plans on behalf of employees receiving LTDI benefits. LTDI premiums are waived while receiving benefits, as are union dues.  |

# **Appendix G: Long Term Disability/Teachers**

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| Description  | Also called “private long-term disability plans,” LTD plans were “established to fill the gap left by [relatively low paying] C/QPP-D, Workers’ Compensation and auto insurance” (Roeher, 1992, p. 6). A bias exists in this system “toward coverage for higher income earners such as management employees, public sector unionized workers, and employees in large manufacturing operations” (p. 6). Relatively generous benefits are provided “for a much broader range of disabilities” (p. 6), but primarily for those with disabling illnesses. |
|  | BC Teachers’ Federation (BCTF)/Salary Indemnity Plan (SIP)The BCTF Salary Indemnity Plan is an employee-pay-all disability plan. This means that the plan is funded by BCTF member contribution. The BCTF Salary Indemnity Plan (BCTF SIP) contracts the Great-West Life Assurance Company (GWL) to adjudicate claims medically and to make long-term disability benefit payments. GWL has been given the responsibility for the assessment of entitlement to benefits. The costs of the benefits are paid by the BCTF SIP, though the cheques are issued by GWL. | Alberta Teachers Association/Alberta School Employee Benefit Plan (ASEBP)ASEBP’s Extended Disability Benefits (EDB) plan is a total disability plan. If an employee is unable to perform normal duties due to illness or injury, ASEBP's EDB plan provides income replacement and ensures they receive appropriate treatment during the recovery process if their claim is approved.Interestingly the AB Teachers Association Sick Leave and Extended Disability Benefit Guide exhorts teachers to proceed with caution regarding specific aspects of the process of applying for disability benefits, and appears to read the employer with suspicion.  |
| Eligibility | Plan provides both short- and long-term benefits to teachers who, due to illness or injury, are disabled from working. If the illness or injury is work-related, a WCB claim must be initiated. The plan applies to all active BCTF members with regular assignments, whose first date of eligibility to receive benefits occurs on or after September 1, 2016. Members whose first date of eligibility to receive benefits is prior to September 1, 2016 continue to receive benefits based on the plan in effect at that time. Claimants must be less than 65 yrs of age.A member who becomes disabled through injury or illness is eligible for benefits immediately following the termination of sick leave and Salary Indemnity Plan short-term benefits, when no fewer than 120 days of benefits have been paid for that claim.Effective date of coverage:A member is eligible for benefits under this plan as follows:Short-term benefits— from the date he/she is first actively at work.Long-term benefits —from the twentieth or later day of employment exclusive of sick leave.The Salary Indemnity Plan defines disability depending on the length of time the disability continues. Disability means either a physical or mental illness or injury. There are two definitions of disability in the SIP long-term plan: one for the first 12 months of benefits, the “Own Occupation” period, and after that for the “Any Occupation” period. Own Occupation: To qualify for benefits a claimant must continually for a period of up to 12 months commencing at the expiration of the qualifying period, be suffering from a disability that prevents the claimant from performing his/her normal employment duties. Any Occupation: If your disability lasts beyond the first 12 months of long-term, you will qualify for continuing benefits if disease, illness, or injury prevents you from being gainfully employed. subsequently, be suffering from a disability that prevents the claimant fromperforming the duties of any gainful employment.SIP defines gainful employment as:* work that the claimant is medically able to

perform.* work for which the claimant has the requisite qualifications by reason of education, training or experience.
* work that provides a gross employment income of at least 60% of pre-disability gross employment income, and within five years of starting the new employment. Adjusted annually to the cost of living allowance the claimant would have received since the date of disability.

Receipt of benefits for an illness which is caused by drug or alcohol abuse shall be contingent upon the claimant’s enrolment and ongoing participation in a substance withdrawal program recognized by an addiction medicine specialist. | For purposes of determining whether or not an employee qualifies for EDB, total disability means that: • during the first 90 days of injury or illness (referred to as the 90-day elimination period), the employee is totally and continuously unable to perform the duties of their normal occupation • until the earlier of August 31 or January 31, during the 24 months following the 90-day elimination period, an employee continues to be totally and continuously unable to perform the duties of their normal occupation resulting in a loss of 30% or more in pre-disability earnings • after 24 months of disability, the employee is unable to perform the duties of any occupation for which they are, or may become, suited through education, training, or experience which provides him/her with an income of at least 60% of pre-disability earningsTo be eligible for Extended Disability Benefits (EDB), an employee must have EDB coverage and meet the definition of [total disability](https://www.asebp.ab.ca/redirect.aspx?EC=HLEVEL&EN=Benefit+Guide+(EDB)+-+Coverage+Summary) at the time of the illness or injury. An employee is not eligible for Extended Disability Benefits if at the time of the illness or injury s/he did not have enough hours worked, discontinued benefits during a leave of absence, or if s/he has a [pre-existing condition](https://www.asebp.ab.ca/redirect.aspx?EC=HLEVEL&EN=Benefit+Guide+(EDB)+-+General+Limitations).To be eligible for enrolment in an ASEBP benefits plan, an employee must fulfill all of these specific requirements: • s/he must have completed one day of service and be working in the regular and active service of his/her employer • s/he must be working a minimum number of regular hours that is equivalent to at least a 0.2 Full-Time Equivalent (FTE). Some employers may have adopted a higher number of minimum work hours or have a specified waiting period in accordance with the collective agreement or management policies. • s/he must be covered under a provincial health care insurance plan • s/he must be under the age of 65 • s/he must be a resident of CanadaBenefits continue to be paid for as long as the employee is disabled or until the end of the month following the month in which s/he reaches age 65. |
| Access | All claims for benefits should be accompanied by forms required by the plan administrator, specifically:(a) claimant application form signed by the member; and(b) a medical form signed by a licensed physician, nurse practitioner, or registered midwife, or in special circumstances, a notarized statement signed by the member; and(c) the school board verification of sick leave form signed by an official of the employing school board or local association or the Federation.If disability prevents a teacher from working for six months or longer, and if s/he anticipates a long illness, s/he must apply for Canada Pension Plan Disability benefits. BCTF SIP long-term disability benefits will be reduced by the amount of potential Canada Pension Plan Disability benefits unless the teacher can show proof of application for or declination of Canada Pension Plan Disability benefits. A member in receipt of benefits for more than twelve months shall provide proof of acceptance or denial of Canada Pension Plan benefitsA member in receipt of benefits for more than three months will be required to provide supporting medical evidence indicating that he/she is receiving ongoing care and treatment by a licensed specialist physician for that disability, or a registered psychologist as directed by a licensed physician except where the plan administrator is aware that the disability is terminal. | Disability benefits become payable only after a 90-day elimination period. The elimination period is defined as the time from the start of total disability to the 90th consecutive calendar day of total and continuous disability. The start of total disability is the date of accident, injury or medical incident and is usually the day after the last day worked. However, if an employee is on a regular scheduled school break (i.e., July/August, Christmas, or spring break) then the start of the elimination period will be the date they become totally disabled (not the day they were scheduled to return to work).If an employee believes that s/he may be away from work due to an injury or an illness for more than 90 days, they should inform the employer as soon as possible. The employer initiates a claim for EDB with ASEBP on the employee’s behalf. As soon as ASEBP is advised of the pending claim, the employee will be contacted by an EDB Intake Facilitator. The EDB Intake Facilitator starts the application process as early as possible to ensure a smooth transition from sick leave benefits to EDB, and will continue as the primary contact throughout the application process.The EDB Intake Facilitator forwards an application package to the employee. The package includes information about disability coverage, a brochure called Applying for Extended Disability Benefits (EDB), and the following forms: • Employee Statement - to be completed by the applicant • Release of Information - to be completed by the applicant • Physician Statement - to be completed by a general practitioner • Medical Statement - to be completed by the appropriate treating specialist, recognized by the College of Physicians and Surgeons of AlbertaEmployees are responsible for all costs incurred in obtaining medical reports for their claim application.Claim information, along with all documentation supporting disability, must be submitted within 12 months from the end of the 90 day elimination period. If the information is not submitted within this time frame, the employee forfeits the right to apply for Extended Disability Benefits. |
| Coverage | SIP long-term disability benefits are payable monthly at month end, including July and August, and are non-taxable, because it is a self-insured plan.Members on SIP receive full pensionable and contributory service credit for the portion of time for which they receive benefits. SIP does not cover (medical/extended health/dental/life insurance) benefits. A member applying for SIP is encouraged to consult with their school district or local union office to inquire about maintaining benefits. In some cases, the school district will continue to cost-share the benefit premiums for a period of time. SIP does not pay CPP and EI premiums. A member, in receipt of disability benefits, is not employed by the SIP. Therefore, CPP contributory time is not credited and disability benefits are not considered insurable earnings under the EI mandate.Benefits are based on gross annual salary applicable on the last day of work or sick leave. The gross annual salary applicable on the last day of work or sick leave shall be adjusted due to salary increases negotiated retroactively.The benefit is calculated as:• 65% of the first $40,000 of salary,• 50% of the next $40,000 of salary, and 40% of the balance of salary.Expenses incurred by the member in obtaining medical certificates or other requested information under this regulation are borne by the member. The only exception is when a member is required to submit to an independent medical examination (IME) by medical professionals selected by the plan administrator. Accommodation Employment is defined as receiving long-term benefits while working or volunteering. This may include working part-time, reducing a claimant’s assignment to accommodate disability, self-employment, volunteering, or participating in a workhardening plan with the BCTF SIP Health and Wellness Program. Long-term benefits are contingent upon approval from BCTF SIP for the Accommodation Employment.If applying for long-term benefits and involved in any of these activities, claimants must complete an Accommodation Employment Application. This application must be completed and signed by the claimant and physician. If receiving long-term benefits and considering initiating part-time work, self- employment, or volunteering, claimants must seek prior approval from the BCTF SIP with an Accommodation Employment Application.To assist teachers who are or who become disabled to maintain or to return to their teaching positions as early as possible, the BCTF SIP provides a voluntary Health and Wellness Program. If a teacher is unable to return to work because of disability-related barriers, the BCTF SIP may provide a Rehabilitation Consultant to assist him/her. The Rehabilitation Consultant works with the teacher, his/her family, and health care providers to restore or improve health and functional capacity. | ​ ASEBP works with employees and the appropriate health care providers to design individualized plans to assist them through the recovery period and prepare them for return to work. An individualized plan may involve either rehabilitation employment or accommodation employment.The website does not indicate if the benefits are taxable.The disability benefit amount is based upon the monthly earnings in effect on the last day of the [90-day elimination period](https://www.asebp.ab.ca/redirect.aspx?EC=HLEVEL&EN=Benefit+Guide+(EDB)+-+90-Day+Elimination+Period). Any retroactive salary changes that become effective prior to the 90th day will also be included in the benefit calculation (e.g., collective bargaining resulted in all teachers receiving an increase). ASEBP offers two Extended Disability Benefits plans:Plan D • 70% of basic monthly earnings, to a maximum benefit of $17,500 per month • all other sources of income must be reported and may be deducted from the EDB payment • the employer must pay all or part of the premiums, meaning that benefits payable under this plan are subject to income taxPlan E • 66 2/3% of the first $2,500 of basic monthly earnings plus 45% of any additional basic monthly earnings, to a maximum benefit of $11,792 per month • all other sources of income must be reported and may be deducted from the EDB payment • the employee must pay 100% of the premiums, meaning that benefits payable under this plan are not subject to income taxThe ASEBP disability benefit may be reduced by the amount received from other sources. These include, but are not limited to: • Disability benefits from Canada Pension Plan (CPP), Workers' Compensation or other disability plan • Automobile or general liability benefits • Employer sick leave benefits • Severance, termination pay, or other remuneration received from any employer • Self-employment income • Pension income such as CPP, Alberta Teachers' Retirement Fund or Local Authorities Pension Plan will be deducted if it exceeds 85% of the combination of pre-disability salary and income from the pension planASEBP waives premiums for the following benefits: • Life Insurance • Accidental Death & Dismemberment (AD&D) • Extended Disability Benefits •Extended Health CareIf the employee was participating in Dental Care or Vision Care coverage, s/he may continue these benefits; however, these premiums are not waived—there will be a charge for these benefits. The employee should check with the employer about who is responsible for payment of these premiums during disability.  |

# **Appendix F: Work Disabled Participant Narratives**

## **B.C. PWD Participant Narrative**

(R. in verbatim quotes denotes researcher)

J. is a young woman living alone in a ground floor condo, which she owns, with her dog and cat, in neighbourhood just outside of the downtown core of a large urban centre. The interview was conducted in person at her home. She has a social work background, and up until the previous year had been pursuing a Master’s in Social Work (MSW) at a local university. During our conversation she reveals she lives with several chronic episodic conditions—fibromyalgia, depression and anxiety. Our conversation begins with J. recounting what was happening in her life at the point where she decided to apply for BC-PWD.

A number of years ago—she didn’t say how many—J. was working full time at a local homeless shelter, work she was struggling with due to her physical condition, and wanted to apply for PWD. She found herself going to work and then the rest of the time just recovering, so spoke with her doctor about applying for benefits. Her doctor, who had diagnosed the fibromyalgia, told J. emphatically that, “fibromyalgia is not eligible for Disability.” [PWD] J. chose to believe this at the time, and in response decided to return to university to complete her MSW, rather than work. Attending university was “so stressful” and exacerbated her symptoms, but it also meant she was able to see a campus doctor. In her words, “Having a supportive doctor has made such a big difference for me. Not just around disability but just in general.”

In her second year of graduate school, J. did a practicum with the provincial government, which took a full semester longer than other students to complete. During the practicum, which she enjoyed, she noticed she was experiencing symptoms of depression and anxiety. Despite this, J. believed she could be both attending university and employed, as during her third year of university she was taking only one course per semester. Unfortunately, she found working even two or three four-hour overnight shifts at a homeless shelter (at a church) exhausting—“I would be late for my 4 hour shift. So it was…like all of my time is spent getting ready for those three 4 hr shifts. And I'm not doing anything else other than just preparing myself for those.” J. was also offended by the “security” tasks expected of her that required her to segregate homeless people from the church congregation.

Again, she decided to try and apply for PWD. Around this time she attended a fibromyalgia support group, and during a discussion about PWD discovered her doctor was mistaken about people with fibromyalgia applying for and receiving PWD benefits.

Applying for benefits

J. is fuzzy about some of the details but believes she spoke with her GP at the university about applying. She called the Ministry office and was told by the worker, "You can't just apply for Disability you have to apply for welfare.” J. applied online for welfare and was declined. The ministry

said my parents would have to stop loaning me money. And when I told them like if my parents stop giving me any money—they’re only giving me like $675—so I can't pay my mortgage, I can't afford to live. I'm going to lose my housing. So they said that I could apply for Disability now that I've been told I couldn't … I was not eligible … I was not financially eligible for income assistance. But the financial stuff changes with Disability, so I was financially eligible for Disability, but then I had to go through the process of whether the physical and mental health stuff qualified.

J. was told that she was now on the Ministry “radar” as “someone that they’re dealing with” because she has applied for welfare, despite being declined. She was also told she has to actually go to the Ministry office downtown to get an application form for PWD. It is not an online process. She describes aspects of the experience as “daunting.”

You sit there and wait, and it's always a really long wait and then I had to go up and they had to check and see that yes I had been told I could apply for Disability. And then she went and got me my application form like it was gold (laughs), you know, and brought it over, and she had to sign all this stuff on it which …

R: And what do you think she was signing in there?

To show that this was an official form that had been picked up in the correct manner.

Interestingly, later, when she had to redo one of the sections of the application, necessitating a new application form, when she went to the same office the application form was just handed to her without question or signature required. She reflects on the form:

It’s incredibly daunting to look at that form and think you have to fill that whole thing out. And I'm someone who has a lot of education, and has done stuff like that and has helped other people with forms, and am pretty comfortable with them and I found it incredibly daunting.

R: What was so daunting about it?

Just that there was so much information, and that it was so personal and that it … it doesn't feel … like I'm not in any way making light of stuff but for some people for some disabilities it's really clear —I don't have a leg, you know? I'm in a wheelchair I can't walk — it's really clear. And I felt like describing depression and the weird pain of fibromyalgia seemed really, really a challenging task. I wouldn't be able to describe it.

R: You didn't feel like you could describe it well enough so that you can get the benefits.

Yeah.

Beyond her concern about being able to describe the complex conditions with which she lives, she recounts how the difficulty doing so for the first section of the form resulted in an initial decision not to complete this section. J. begins by describing the structure of the form:

There’s just three sections of the form— the first section the applicant fills out, and the next section is the doctor, and the third section is the assessor. And the first section it says you don't have to fill it out? It says you can fill it out but it is not mandatory that you do it. The Doctor and the Assessor's sections are mandatory. You don't have to fill out your own. And I was not going to do it.

R: You were not going to fill out your section?

Because it just seemed way too difficult.

R: Did it say anything about if you don't fill this out it might jeopardize your chances? Or anything like that?

No, I'm pretty sure it kind of just says it's not mandatory but it's your opportunity to tell us what goes on for you.

J. clearly understands the stated purpose of Section 1 of the form — titled Applicant Information — which includes a subsection titled “Disabling Condition.” From the application:

This section provides you with the opportunity to describe your disability and the impact it has on your life. You are not required to complete this section. If you do not complete this section, your application will be considered based on the information provided in the Physician and Assessor Sections of this Application.

Two separate questions are asked and space is provided on the form in which to write answers. Question 1: Please describe your disability. Question 2: How does your disability affect your life and your ability to take care of yourself? The second question is critical because the definition of disability for official purposes includes a person’s ability to take care of themselves, whether or not they receive assistance to do so. As such, it is more or less a measure of independence, and applicants may not be aware of this critical aspect when answering the question.

Initially, J. asked her doctor to complete both the Physician and Assessor sections of the from, which MDs can do. Her doctor was really supportive of her doing that, and “made me feel like I wasn’t being a nuisance, which is a big deal when you’re doing something like that!” J. didn’t talk to her doctor about the Applicant Information part of the form because she didn’t want to put herself through completing this portion, so decided she wouldn’t, mostly because it felt really personal and difficult.

Her doctor completed both parts of the form, but before J. could submit the application she was speaking to one of her professors about her difficulty, and what she was going through, and the professor recommended a nurse who helps people complete the forms, and herself completes the Assessor section of the form. This individual is self-employed and J.’s parents helped her out with the nurse’s fees. She met with the nurse a couple of times to discuss the process, and for the nurse to get information from J. to complete the Assessor portion of the form. The nurse created a draft copy for J. to review before completing the actual form for submission. J. believes this nurse’s assistance made the difference in terms of being approved.

I’m really lucky that my parents helped me out so they were able to help me pay for that. Because I do think it's unfortunate that that's not available to everyone. Right? [uh huh] I know I'm in a really, really privileged position to have my parents help me out. But yeah it was it was really helpful to have that. I don't think I probably would have been approved the first time.

J. decided to complete the first section of the form after she is advised and assisted by nurse to do so. I ask how the nurse helped her.

I think for me the biggest help was just being encouraging that I was on the right track. I believe she gave me a list of questions which really helped focus because I believe my first draft didn't have enough detail in it. And so she gave me some questions to look at as far as like what actually happens on a day-to-day basis. [uh huh] Like what are you struggling with here? I can't remember exactly what they were but just having those to focus on helped.

R: I know that one of those application form questions is about what the disability is, and the second one is about how it affects your ability to take care of yourself.

That's right. Initially I had not done the second part [uh huh]so that was really … that was really helpful to know to focus on those aspects of it. And also really encouraging me to not minimize what was going on, and to say … like to look at things as on my very worst day, not just in general, or not how I might be on my best days. On my worst days what happens?

The nurse also made suggestions about how her doctor could strengthen the Physician Section of the form:

I think that she understood because when doing the form and I think … you know doctors are not looking at what is happening on your very worst day. And so when I explained to her [her doctor] that that's what we were doing, and that if you're iffy on something just because … you don't want to say this happens all the time you're not going to say that … so you say this can happen. And that kind of language is totally fine for doctors. It makes it sound like it's not really bad … it only happens sometimes … it might happen … and so yes that was the type of language that she changed in it.

R: You wanted her to be more definite — this does happen and … it happens … regularly?

Yeah. And this is an issue. I can't remember exactly what they were, but it was that kind of thing where it was just indefinite or kind of wishy-washy.Yeah, to make those more definite, like this happens, this is an issue, that type of thing.

J. shares her frustration with the fact that the application process is not computerized, especially given her decision to have the nurse complete the Assessor section, and request changes in the Physician section by her doctor:

I had to get another form because the assessor portion was all going to change. [her GP had filled out both Physician and Assessor sections initially, but the nurse-advocate was also qualified to complete the Assessor portion] I have to say one of the things for me that's really frustrating about the process as a whole is that it's not computerized. That seems ridiculous to me, partly because the forms that they have don't provide enough room for people to fill out. And for both the assessor and my doctor they're like scribbled on the side and everything. And you're also expecting the people looking at the forms to read people's writing that's really cramped 'cause they didn't have much room. I think that is a real issue yeah because I think a lot of doctors don't want to sit and write and may not be willing to go through it in as much detail as they maybe should. I think that's kind of asking a lot of people to do it that way at a time when we don't need to.

R: And it takes a lot of time. [yeah] Mind you being on computer can be difficult for some as well, but that option is not there, as you say.

No. So yeah I just … for me that was a very frustrating part 'cause it also meant if I'm getting someone to redo something they can't just make a couple of changes on the computer — they had to rewrite the whole thing. So yeah. I just think that that really limits what people can do.

Applying for benefits took from May to October in the year she applied, including beginning with the application for income assistance (welfare). J. describes the reasons for this:

I initially contacted her [the nurse/Assessor] — and I think we met fairly quickly after that. But then I also had to take things up to the doctor. Yeah, it took a while. A lot of it on my end because I was working on my stuff. That's what kind of held it up. It took awhile to do. Actually filling that section out was really hard. It was way harder than I expected actually. I think it's really difficult to … to talk about yourself that way. It was really hard to say I can't do this, this happens to me [uh huh]. Yeah, because you know you tend to think, “try and think positive about things” and it's a really negative way of looking at what's going on because you're trying to present it at its worst, and so it was a “Wow I'm really limited!” It was really … it was hard.

J. found that her depression worsened during this period, in part because she lives with invisible disabilities and is exposed to and feels the judgement of others about whether her condition is as bad as she says it is, which prompts questions about whether she really deserves the disability benefit.

I wondered how soon after she had submitted the form did she hear about being approved for PWD Benefits. She described to me what she called “a big crazy mess” that lasted until early February, during which time she did not receive any benefits. J. began calling the Ministry office every couple of weeks to check on the status of her application. In early December, she was told over the phone her application had been approved. She assumes that her approval included both the health aspect and the financial aspect, the latter because she understood that she had already been approved to go ahead with the PWD application, after her welfare approval was financially rejected. During the six-month period between learning she couldn’t apply for welfare/income assistance and her application submission for PWD she hadn’t been on any kind of claim or reporting any financial information to the Ministry. Apparently, she was now required to submit documents to establish financial eligibility for PWD Benefits, and was instructed to appear in person at the Ministry office. As she recounts:

I needed to go down to the office and talk to someone there, and I don't remember what, but she said — "You have to go down and talk to someone." I went down and waited in the line again, and the woman was like, "Yeah I don't know why you're here, there is no reason for you to be here.” Someone will be phoning you, you will have a worker who will phone you. I was like "okay." So I was waiting, and they told me they'd sent me a letter that explained everything. So I called again the next week — I wish I kept track — but I called between 6 and 8 times in December and was continually told sort of different things, but always like "Yup, it looks like there's an approval. We sent that letter out. Don't know why it's not there yet, and no everything's fine, everything on here looks good, someone will be getting in contact with you."

But J. had not received a letter from the Ministry yet confirming her approval for benefits.

But I don't have that letter and … so finally in early January I talk to someone — and I was getting really frustrated 'cause they keep telling me someone is going to call and no one is calling — so I finally talk to someone and I don't know what I said but she's like, "I'll let you talk to my supervisor." So she passes me to her supervisor, and it turns out that … first of all, the letter never got sent, so they said they would re-send it to me. And the letter has a lot of information in it, which would have been really helpful to have, and also there's some code — I have no idea what code she was talking about — that was wrong. Which is why no one has phoned me. So even though I've called six to eight times which means I've had six to eight people tell me "You're good to go, everything's fine, someone will get a hold of you" — they were all wrong.

J. realizes from this experience that when you call the Ministry number the people you talk to are not actual Ministry workers in her opinion; they don’t actually know details (or have access to details) about your file. What is frustrating and confusing is applicants think they do, and they tell you they do, but until you actually speak to an “actual disability worker,” as she describes it, you’re liable to be going around in circles trying to discern what is really happening. Interestingly, she also surmises another possibility for the confusion — the people on the phone just don’t care enough to bother to look more closely at her file. She summarizes it this way (in a disdainful tone): "Whatever. You're just some like Disability applicant. You're not deserving — we don't have to put an effort into this."

After J. received the letter stating she had been successfully approved for benefits stating she would get a cheque in late December for January — it’s not clear when she received the letter — she learns she has to deal with the financial aspect of the application process again. She was confident that she would be successful because she had no income. This process was as onerous as the previous one, although in a different way, because she had to provide the Ministry with paperwork — banking information — and it got misplaced, creating extra work and frustration for J.

I had to get bank statements for three months, a bank profile from all my bank accounts — I have two. So I had to get the information about my mortgage, all my insurance costs for my car, all my utilities — all that financial information I had to get to them.

R: And what would a bank profile be?

It tells —s o I could go in and give them just my bank statement, but maybe I also have $500,000 in investments or something else in the bank. The bank profile says this is everything that you have. So I guess I could forget a bank (laughs) and not do anything from a bank that I had, but yeah, it just means that they're getting all the information about you at that bank.

R: So you had to gather that up in hard copy. [yeah] And you had to take that into them?

Um … you can drop it off, or you have to go down there but you can either drop it off, or …

R: Is that what you did?

I waited to talk to someone just to make sure. That also was very frustrating because I went down and so she went and she photocopied everything that I had, and scanned it in and sent it off. And then when the guy … they called me back and told me that I needed to provide the bank profile from both my banks and the bank statements from one of them, 'cause they only received bank statements from one bank. And I was like, "Well I gave you all of it. It's gotta be there somewhere. And so this something that frustrated … 'cause to me it seems like "I gave it to you. Can you not just look and find it?" But they were like, "No" — I have to bring it down again. And it was very frustrating 'cause they kept saying, "You didn't bring it." And I kept saying, "No I did." I felt like saying, "your worker screwed up." I brought them all in. Why do you think I would have brought in the bank statements from ONE bank and not the other, and not the bank profile? Like no, I did it. So it was very frustrating … I was really angry actually, because they kept saying that —" Well since you didn't bring that in, since you didn't provide that." And so that was very frustrating. But then when the guy who called me— the worker—he also told me they were not there and I was SO frustrated at that point [I bet] and he called back a while later and said he found them. I don't know what happened there but … 'cause I dropped them off twice. I would have been so angry if they hadn't been there the second time.

R: So when did you actually learn that you had been approved financially?

It was right at the end of January.

R: And did you have to make any further calls once you talked to this fellow at all?

No. The only thing I had to do was give them my … I had to go down and sign something. Like paperwork.

R: So that was just to just verify that that was your banking statement, or what?

No. Just my agreement with them about them giving me money. So I had to go down and sign that and get them my … for direct deposit.

Her first cheque finally arrived in the first week February and included her missed January payment. As a social worker who has dealt with homeless people, people without the advantages she acknowledges she has, she is sympathetic to those who might get caught in the same bureaucratic maze.

I just think I'm not alone and the thing that really upset me about it … is, again, I know … I've done these things, like I am as comfortable with them as you're going to get. And I just know so many of my clients at the shelters would not have been as persistent as I was and like I know for me they would eventually just … they wouldn't say, "Oh wait this person has not contacted us" — it would just expire.

R: Uh huh. Then they'd have to start all over again.

Yeah, yeah. Like right from scratch — get the people to fill information out again. Like I know people who just would not go through with that again. And I mean who would when it didn't happen the first time, why would you think it's going to happen the second time? Why would you go through that? Yeah, like I really feel that …it seemed in many ways … and I'm not saying it's purposefully set up this way, but it really seemed like there were a lot of things in there that were trying to push you away from going through with it. From the difficulty in getting the application initially, like that I had to sign all this stuff and make it seem like a big deal. I don't know. There were a number of ways where … one of the big things is the woman [nurse/Assessor] who helped me fill out the application also gave me some resources on how to fill out the Disability application. And that was so helpful but I didn't get that from the Ministry. Like why didn't they provide me with something like that? It just seemed like … those applications are not easy to fill out — having a guide would be really helpful. So why are they not making that effort? It seemed … the whole handwritten thing to me seems like a real stumbling block for a lot of people. It really ended up feeling to me often that they were like, "If we make this hard enough we won't have to give away our money." Yeah. I mean I don't know that that's true, but that is how I felt going through the process.

I ask J. If she was required to apply for CPP-D, as I understand it is a common practice for those applying for PWD Benefits to offset the costs to BC for supporting disabled people. J. responds that she was not, although did have to apply for EI. In telling me this she makes a critical comment:

And I'll be honest …I still don't quite understand what the difference is or how you go about applying. And like who's supposed to apply for that as opposed to PWD? I have a friend who's applying for Disability right now who has very similar to me fibromyalgia and depression and anxiety and um … she was on WCB for a long time and has found it really frustrating that there's no easy way to transition from the WCB to PWD or CPP. She had to like finish that [WCB], and now she has that whole however long —six month, eight month period — where she's not … where she's getting just income assistance [welfare]. And so … like it just seems like there are just a whole lot of different types of Disability [meaning programs].

R: There are!

And I don't understand how … I don't think they work together. I don't think there's any kind of bridging to help someone move from one to another. And it seems like they all have their own criteria [yes]. So you can't just say, "I'm eligible there. I should be eligible here." And so the one that they made me apply for is EI. And I had to bring in a thing saying I had been declined from EI. That was the one that I had to do.

I ask J. what kind of difference it has made for her being on benefits, and she tells me it’s a huge relief both for herself and her parents, who can now save more money. Her parents continue to provide income for her — $1000 monthly as opposed to $2000 they had been giving her previously. J. had to submit a letter to the Ministry from her parents providing the amount and the distinction that this money was a loan, not a gift. She also received medical coverage, in particular for the medications she is prescribed, and dental coverage — all this was in the letter that they didn’t send initially. I ask how she finds information about coverage and she was told by the Ministry worker — the Disability one — that in the case of dental coverage she should call the dentist and ask what kinds of services she can receive while on PWD Benefits. The same applies with medication — some prescriptions are fully covered, others are not — she finds out by speaking to the pharmacist. One of her prescriptions normally costing $300 she now pays $100 for.

One significant benefit for her is very affirming, that is, the recognition that she does indeed have a disability and is not making it up.

Interestingly, she is also allowed to go to school full time, something you cannot do on income assistance/welfare. The Ministry worker asked why she had a university-based email address, and she told them she was a graduate student temporarily withdrawn for 8 months for health reasons. J. told them she wanted to go back to school (in January) and was told: “Well when you're on Disability that's OK.” Interestingly, she used up most of her energy the first week back at school dealing with the Ministry financial paperwork demands, instead of her studies, which made her angry. I asked if the Ministry was helping with tuition — they aren’t — but she can apply for a student loan, just not for living costs, because that would interfere with her PWD Benefit.

After the recorder was turned off, during the ensuing conversation J. made a couple of comments that I made a note of. I sent them to her for her approval, which she did with one small change. The notes are as follows:

-I found the whole application process especially with respect to how I was treated by Ministry staff frustrating. They know that the benefit is worth around $1200 monthly, and what my living expenses, mortgage, utilities, car expenses are, so why do they need to know all my bills and stuff, like phone, etc.?

-I found the process of reporting my financial situation unnecessarily invasive — they are not giving me enough to pay for everything, so why do I have to provide that information?

-It made me feel like an undeserving person — we have to give all that private information to them because we have nowhere else to go. They don’t need to have all that information but I have to give it to them.

-Also, there was an attitude of “We don’t have to cater to you in any way—we’re not a customer service organization. We can give you crappy service and there is nothing you can do about it.”

-The process of applying made it feel this way — you don’t deserve any better than crap.

## **WorkSafeBC Participant Narrative**

S. is a middle-aged First Nations woman living in a small village of about 900 people west of Prince George BC. She has three daughters, one attending UBC (and recently arrived home after her second school year at the time of the interview), and twins in their thirties living for the past seven or so years in Los Angeles, working in the fashion and film industries.

Our interview was conducted via Skype, from the community First Nations’ (FN) health centre where S. lives, following a short series of transmission problems.

S. worked as a unionized track maintainer at a Canada-wide railroad company at the time of her injury in mid-August 2014. On the day of the injury she was working with a younger worker—23 yrs old — replacing railway ties and doing some surfacing that included using a jackhammer. After this work, cleaning up back at the tool house they decided to move a railway tie a couple of feet. As per safe workplace practice they reviewed how they were going to lift it and to where, but as soon as her co-worker lifted the tie “he swung and let go without warning [oh no!]. Yeah and I had a good grip on it because it is heavy and I just went with it without warning and I heard a couple of pops in the back of my neck.”

The next day S. started having tingling in her hands, and a bit of numbness so reported these symptoms to her foreman the next day. She was unsure if the tingling was a result of the jackhammer work or the accident moving the railway tie. Almost right away the symptoms began to worsen, the tingling spreading to different areas of her body, so she saw a physician two days later. Apparently according to “their” rules [not sure if she means the company or WorkSafe BC] “a supervisor was supposed to go with me to the doctor's appointments if it's maybe work related.” It’s not clear if a supervisor or foreman accompanied her to the walk-in clinic where she saw the doctor, but she mentioned that she did tell her foreman she was going to the clinic.

At the clinic the doctor seemed to attribute the tingling to the use of the jackhammer, which S. tells me really shakes your body, but she is careful to note that she and her co-worker followed jackhammer use protocol — “I told my foreman, like we reported it, like — we took turns using the machine and we never did it more than you know 20-30 mins max per person. [uh huh] So we were very careful about that.” The doctor wrote her a prescription for Vitamin B6 pills and sent S. home. When the tingling and numbness became progressively worse, such that she couldn’t identify separate items in her pockets, the hairs were standing up on end on her abdomen continuously, and her feet felt like she was walking on gravel, S. went back to the same walk-in clinic a couple of days later and saw another doctor, who asked her what happened. He also asked if she was on any medications. She had neglected to tell the previous doctor she had been on birth control pills for a couple of months for the first time. The second doctor told her to stop taking the contraceptives and chastised her for wasting his time — he “went on to tell me that this is an emergency room and he's here to treat emergencies.” But S. says she wouldn’t have been there at 8 pm if there hadn’t been something wrong, that felt like it needed immediate attention.

Although it’s not clear when, S. saw her family doctor who ordered blood tests, which she thought was odd, given she believed strongly her problems were from a “pinched nerve in my neck.” At this point she had not filed a WorkSafe BC claim because she was trying to figure out what was going on with her health. S. had seen “about five” doctors at this point, including a fairly young, newly-graduated doctor who told her,

“For that to happen [a pinched nerve] and the symptoms you have you would have to have it in two spots of your spine.” Because I was having intense feet and the back of my thighs felt like there was elastic bands around them. And she told me, "If that was going to happen you're better off buying a lotto ticket because the chances of having a pinched nerve in two parts of your spine at the same time that could give you these symptoms, you're better off buying a lotto ticket.”

In other words, the doctor thought it highly unlikely that S. would have a pinched nerve in two sections of her spine. In fact, every doctor she had seen to this point communicated to her it could not be a pinched nerve because of her symptoms.

A lot of time was taken up by S. travelling to see doctors because the emergency room and walk-in clinics were an hour and two hours away (Prince George) respectively. At the latter emergency walk-in clinic S. told the doctor she was having difficulty holding a coffee cup or she thinks that she is holding onto a cup and it falls, her perception of space when reaching for objects was impaired, and she couldn’t put a pair of work gloves on. After two weeks of progressively worsening symptoms and trips to various physicians, S. told the doctor she was seeing at the time that she couldn’t work any longer. She tells me that because she took her self off work she ended up applying for short term disability, apparently part of her extended health benefits as per her union contract (United Steelworkers). At the same time, she also applied for WorkSafe BC benefits despite the fact that the doctors she was seeing told her it couldn’t be a workplace injury because of the symptoms she was experiencing.

The doctor she saw in Prince George (PG) sends her for a CT scan, which she waited another week to have and then again a few more days or so for the results. S. had to travel 2 hours one way to PG to see the doctor, then back home, then again to PG for the scan and return home, and then again to PG for the results. The results showed she had enlarged ventricles in her brain, so the doctor sent her for an MRI, which happened about four weeks later in PG. She was also being tested for MS, which didn’t make sense to her “it just didn't make sense to me why this happened to my neck and all of a sudden I'm having these symptoms that could be some sort of disease. It just wasn't jibing with me. And just didn't feel right.” S. is also told to go for walks and exercise as usual. At this point she and her boyfriend were discussing driving to Vancouver to go to an Emergency room there because she felt she wasn’t being listened to and was slowly losing function, for example, she couldn’t feel the toilet paper when wiping herself and couldn’t tie her shoes. She also went for a hike in a hilly area in order to get some exercise. When the results of the MRI reach the doctor in PG who ordered the test, he called S. and asked her to come in immediately, so she and her boyfriend drove to PG right away, because

They found that my C4-C5 discs was severely bulging out. It was like a football shape going around my spinal cord. And it was basically pretty much popped right out. And that's what was compressing on my entire spinal cord. [uh huh] All of  sudden six weeks later I'm having this neck brace put on me, and they're telling me "sit down," [don't do anything] yeah, within two hours I was on my way to … less than two hours … I was on my way to Vancouver —Medivac'd to the Vancouver General.

Within 24 hours of arriving in Vancouver S. had a C4-C5 disc replacement and fusion. The neurosurgeon expressed surprise at the medical treatment she had been receiving —“Oh my god, what were they doing to you?” — and how lucky she was on her hike not have fallen. S. explains: “If anybody … if I had walked into a place … like in a hospital [in Vancouver]… the nurses and stuff would have led me in the right direction. Actually listening to me.” Given her sense that she felt like she was not being listened to up until this point, she too expressed surprise that in Vancouver they didn’t actually question her account of the accident —“ ‘if [names herself] says she has a pinched nerve’ they're not even like ‘let's rule that out’.”

At the time, S. applied for short term disability she also applied for WorkSafe BC benefits because she was maintaining that she had suffered a workplace injury. The doctor who said she should buy a lotto ticket completed the doctor’s sections of both short-term disability and WorkSafe BC application forms for her. They were both faxed from the FN health centre, the short-term disability application going to Green Shields, the plan carrier. Apparently, the doctor wanted to answer in the negative the question on the form of whether it was a workplace injury, and S. requested she answer in the affirmative, or at least say ‘unknown.’ It’s not clear to me which she did. The short-term disability claim was accepted right away, while S. received a letter from WorkSafe BC informing her they were reviewing her case. S. had also informed WorkSafe BC that she had also applied for short-term disability benefits. At the point where she was medivac’d to Vancouver, WorkSafe BC accepted her claim; S. recalls this was “automatic” after she called WorkSafe BC to inform them that she had had surgery.

She received short-term disability benefits at about 75% of her wages for about two or three weeks, then when her WorkSafe BC claim was accepted they back-dated her payments to the date of injury. S. was then required to repay the short-term disability amount from her WorkSafe BC claim, calculated at 90% of her wages, almost $1800 every two weeks, not subject to income tax. These payments were part of the “wage loss” category of benefits, which S. was repeatedly told by WorkSafe BC are temporary. She tells me that the wage loss benefit was meeting her financial needs.

Unfortunately, the surgery did not relieve all her symptoms. She explains:

I was really hopeful that once I had the surgery that everything would disappear. 'Cause they … as soon as pressure is taken off [the discs] yeah the symptoms go away.

R: But that's not the case.

That's not the case at all. And then my feeling … I can feel better the stuff in my purse. Like I can make out shapes better and my grip strength is still off. My perception of reaching for the door and stuff is a little bit off, especially if I'm tired. [sure, yeah] And feeling off balance.

S. admits the first year after the surgery “was like a blur.” She had to relearn textures and how to tie her shoelaces. A year after the surgery, S. was sent by WorkSafe BC to the Canadian Back Institute in PG for a six-week rehabilitation program, travel and accommodations all paid for. She tells me it didn’t help mostly because she was in a group of people recovering from various types of orthopaedic surgery, and S. believed she should have been with people with spinal cord injuries, because of her ongoing neurological symptoms. One of the most troubling symptoms arises when she walks:

When I walk too long and it doesn't take much, my one … left leg goes out to the left like a duck. And I end up limping. I've told them that, and stuff like that is looked over and not addressed at all. And I asked to see doctors while I was there and I didn't see any doctors. I see the kinesiologists to sort of check in each week or whatever but basically … yeah and just "Here, go do these exercises and do these walks." We went swimming … but you know we go for a walk and I'd say "Look I'm limping. I really want to know why this is happening to me.”

Around that time, she received her “first offer of a permanent disability award” from WorkSafe BC at 9.2% of her previous wages, which amounted to $340 monthly until age 65. She disputed the WorkSafe BC time limit on her wage loss benefits:

There's a time limit based on their policies. [sure] I'm like, "I don't believe I fit in within your policies or your guidelines because of my spinal cord injury and them [the doctors] saying it could take years for regeneration of nerves.”

R: So in a sense your wage loss benefits are tied to what is understood to be a temporary state of the injury.

Yeah, until they can push you into vocational rehab.

Along with this offer, or around the same time WorkSafe BC informed her that she would be going into vocational rehabilitation, based on their assumption she could work and earn income beyond the permanent disability award amount. At the time S. did not know the difference between the wage loss and permanent disability award categories, that is, how they are decided on by WorkSafe BC, and received very little information from them. I ask how she figured out the difference.

Well they don't give you … they don't offer you too much information. I asked questions and … um … they never give you the straight answers either, but I said "I can't live on $300 and something. What do you expect me to do? How can you say … I’m only 9.1% disabled? How do you figure that out?" [right] And there's some equation they have and I wanted to dispute it right away, like "What the heck?" [uh huh] So I called the workmen's advisory board. [actually the Workers' Advisers Office].

The Workers’ Advisers Office (WAO), which she learned about from one of her co-workers, became involved after S. told them that she wanted to appeal the WorkSafe BC decision. She was very upset about this decision, especially given she was still symptomatic due to her incomplete spinal cord injury, prompting one of the vocational rehab consultants to later describe S. as quadriplegic. Ongoing symptoms, like her hands and feet becoming ice cold when air conditioning is on, numbness and tingling in hands and feet, phantom burning sensations in hands and feet and muscle twitching trouble her, and leave her wondering if she can work at anything.

WorkSafe BC informed her she had three months to appeal the permanent disability award decision. S. had considerable trouble reaching her adviser at the WAO, who she called repeatedly to enquire about the status of her file. Eventually she called this person’s supervisor expressing urgency. The day before the deadline the adviser submitted a letter appealing the decision. Shortly after, a letter from WorkSafe BC informed S. that her case was going to Tribunal. Unexpectedly, she received a letter from the WAO informing her that her appeal is likely to be unsuccessful.

R: Why would they say that?

They really didn't give me an explanation but … yeah … and so I was really upset. I called my doctors and they're the ones who … you know … you need to submit more stuff because they're saying you're going to lose … and I don't have anybody to work with. November 6 [2015] I called our union and said, "Can you help me? Can you help me?"

S. spoke with her union local’s (western Canada) chief steward, who told her he was going to enlist a union representative from Toronto specializing in disabled workers, and sent her some authorization forms to be completed and then sent to WorkSafe BC (enabling the union to have access to her WorkSafe BC file). At this point, S. is told she can only have one representative, that is, she couldn’t have both WAO and the union helping with her appeal. From what she tells me she decides to relinquish the assistance of WAO — they had suggested she wasn’t going to win her appeal — and thought she ought to begin looking for a lawyer. Unfortunately, there were no lawyers regionally work on WorkSafe BC cases, so she had to look in Vancouver. Most lawyers she spoke with wanted a retainer or to be paid by the hour to review her documents, which she could not afford. Her reasoning was she had paid union dues so the union should be able to help her. But this did not unfold the way she might have wanted it to.

So I was waiting for them, busy getting my documents. You know I would send them emails or send them … like I didn't even talk to the guys long enough … 'cause they don't even know my story. So I’d send emails saying this is what happened and, "Did you get my documents yet?" I kept on getting a couple of paragraphs answer, "No I haven't gotten it." Or "You're not the only worker we're working with, blah, blah blah" [right] Just different excuses like that. I'm like "Why can't we meet with my doctor and (names employer) and WorkSafe BC? Like when's that going to happen?" I trust them but it never happened. There was one time I got my voc rehab and my doctor together, and (names union rep) but it was really a quick call and there was no follow up, like after that.

S. also went to a rehabilitation centre in Vancouver — Orient Health — sent there by WorkSafe BC to see a psychologist and attend classes (she didn’t say what kind). It’s not clear why she needs a psychologist. Again, there were doctors connected to this rehab centre but she didn’t see any while there. While she was looking for more help with the appeal, S. asked her WorkSafe BC case manager if she could see the WorkSafe BC specialist (neurologist) regarding ongoing symptoms. S. was told they didn’t have one and was instructed to see her own specialist (surgeon). She was also told that she’d “plateau-ed. We can’t do anything more for you. Get on with your life.”

So I made a phone call to the surgeon that did my surgery [yeah] and to his private office, and it took eight months or nine months to see him. So that was during that year and a half time, when I was trying to get the union on board with me.

R: Right. What ended up happening?

So, November — I don't remember when I called — it was before I was talking to my union [uh huh] that I asked my (WorkSafe BC) case manager to see this doctor. B ut I didn't get to see him until May 2017.

R: Uh huh. And then what happened?

He sent me for … um … MRI test. I seen his pain specialist and I seen him. And the first thing he said was, "How come you didn't see me at the Richmond (WorkSafe BC) office?" I'm like, "What?"

R: What does that mean?

My surgeon was a visiting specialist doctor at the WCB (office in Richmond BC)!

S. was very angry when this previously unknown fact was revealed to her. When she saw her surgeon he ordered another MRI and referred her to a neurologist working at the WorkSafe BC specialist clinic, who she eventually saw in August (2017). Emails from the union at the time indicated they were too busy to be focus on her case. The neurologist had the MRI results which indicated her C5-C6 was bulging, severely compressing her spinal cord and resulting in swelling of the cord. The neurologist informed her that she should have another emergency surgery, suggesting at first she should stay in Vancouver, that WorkSafe BC would pay for her hotel accommodation, and he would book her for emergency surgery. For some reason he decided to send her back home, instructing her to be careful — “no major bumps.”

On the same day, she received a text message from the union telling her that her case had been won on appeal, apparently one of the biggest settlements ever. S. was informed she was going to receive 42% of her wages in a permanent disability award along with 80% wage loss until age 65. But within days she discovers from the permanent disability award officer at WorkSafe BC that a 10% miscalculation had been made, meaning she would receive 32% for her permanent disability award. The error has never been explained.

A few days after seeing the neurologist in August, S. saw her surgeon in Vancouver to decide whether she would have surgery again, but he wanted to consult with colleagues before deciding and suggested to her that if they don’t do the surgery then “we’ll just hold off for a year.” At this point, after the appeal is settled S. learns from her WorkSafe case manager that because there is nothing more s/he can do for S., she is being referred to vocational rehabilitation. She had 30 days to lodge a dispute.

So I contact my union—I'm like, "Yeah I'm disputing it. I'm not ready for voc rehab. I believe I'm still being treated and I may have this surgery." [yeah] And I called my voc rehab person because they (WorkSafe BC) referred me to one … and I told her, "I may have this surgery and yeah I can't do rehab right now." And she goes, "So you're not participating?" And I'm like, "I'm going by what the doctor's saying." So even though … I forwarded the letters from my surgeon saying I'm unable to work or retrain at this time until my treatment has been optimized … a week later (Sept 7) she sent me a letter saying that I wasn't participating in the process … and I got cut off by over 60%. So now I'm just currently getting the 32% which is $1600 a month.

With her wage loss replacement benefit reduced substantially, S. has been unable to pay her bills and make payments on a truck she bought recently. She describes being “emotional,” in part because a union member has accused her of being involved in a negative campaign against him on social media. Apparently, this union member posted on Facebook that the union had won this “big case,” and a close co-worker to whom she had been talking about how difficult and unsupportive the union had been posted a comment critical of the union. The original poster emailed S. and accused her of “throwing him under the bus.” To add to this difficulty, her employer contacted her saying they heard she wasn’t participating in voc rehab, and because of this they don’t have to provide her with a position that would accommodate her disability. The voc rehab consultant had sent a letter to S.’s employer informing them that she could do an admin assistant job.

S. responded by telling the employer that they had to work with her doctors who said she shouldn’t work at all. At this point she was disputing the WorkSafe BC decisions about her wage loss benefit and the permanent disability award. S. was also in conflict with her employer about accommodative employment, even though she had sent medical documents to her employer, whose response is as follows:

"Medical documents aside, I'm going by what the vocational rehab sent me, and she said you're capable of working." And what they're claiming is I'm capable of working a 10 hour (a week) job. Can you see me? My employer says that she's not going by what I say, the medical information I sent her — 'cause I sent her the letters from a couple of the doctors saying I'm unable to work — and she's not going by what the doctors said, she's going by what the voc rehab person says. And the voc rehab says I’m capable of working. What she said is, "I'll send you some job descriptions that might fit your disability and we'll go from there." But the only place they can accommodate me is in Edmonton. And when I talk to my voc rehab they said that, "If your employer offers you a job and you do not accept, you can get cut off."

S. called the union who informed her she has to comply with voc rehab, and even though she was in appeal and the doctors were saying she could not work, she had to go through the process, that is, apply and compete for the accommodation job in Edmonton or risk being cut off her benefits. She applied for the position the employer suggests would be suitable for her. Part of the application required her to do an online timed reading and writing competency test, the same test she completed when she was originally hired. S. took the test in November, and in early December received an email from her employer thanking her for applying for the position, but that it was given to someone with better qualifications. She forwarded this email to the union, and a week later emailed the union asking if they had heard from her employer. In response the union told S. that the employer informed them that she hadn’t actually taken the competency test. S. took a screen shot of the test completion page, indicating she did complete the test and sent it to both the union and her employer. [She wisely kept every piece of correspondence she received via email or text, and all are archived in a binder, which she refers to during our interview] During this time, she could not understand why the employer was making her compete, given her current status as an employee. She learned from both the union and he employer that she cannot appeal a WorkSafe BC ruling and be accommodated at the same time. Her appeal was based on the fact that she is still being medically treated, was unable to work, shouldn’t be in voc rehab, and should still be receiving wage loss benefits, at least until the medical treatment is completed. The union was encouraging her to take a job that the employer believed would provide adequate accommodation. But S. was of a different mind:

It doesn't seem like an accommodation to me. Accommodation to me is working with my doctors and listening to my doctors."

She has asked the union why they were making her compete for jobs, and they have not answered her. At the time of our interview, she was still appealing the WorkSafe BC decisions and communicating with her union, which has been less than helpful, in particular by recently suggesting she will lose the appeal, may end up getting less in terms of the permanent disability award, and should find someone else to represent her, for example, the Workers’ Advisers Office. In response, S. confirmed with WorkSafe BC that the permanent disability award was not subject to being reduced. In addition, the union informed her via email that she was no longer a union member because she hadn’t paid any union dues since the injury; she had not received any correspondence previously informing her of this fact. This information didn’t seem right to S., so she phoned the national president of the union, who informed her she is indeed a union member, especially as an injured worker, and the union is legally required to assist her.

Within the past week previous to the interview, S. received a letter from a review officer with WorkSafe BC informing her that he has referred the current appeal back to the vocational rehab division. He also informed S. of WorkSafe BC policies that if there is any dispute between doctors, WorkSafe has to favour the worker.

My appeal … they're sort of favouring me in a way that … they're saying that they didn't do the research needed for my injury and in a case like mine it has to be very individual based. And he pointed out that what they've done … they haven't found that. They haven't identified individual accommodation needs for me. And they want them [the employer] to consider where I live. So they're basically saying they can't … they don't think I have to relocate for a job.

Yet S. is still in limbo waiting for a decision and has no idea what this means.

Does that mean that I'll get reimbursed some money? Does it mean I'm still being medically treated? Which I believe I still am, like I'm still … um … having medications adjusted and stuff like that. But it's been really, really, really hard because there doesn't seem to be anyone out there … I've looked online right across Canada because I … even just asking direct questions to … my employer and my union in the same email saying, "Are you guys federally regulated? Or provincially? Who am I supposed to be working with here? [right] You know … (names employer) is a federal entity so what does that mean for me? Especially when human rights comes in. And they have a duty to accommodate me as a disabled person, which they seem to be ignoring.

S. admits that she continues to be symptomatic, and if she does too much it exhausts her for days,

…it feels like I'm totally plugged into some electrical outlet where I'm vibrating from head to toe, and aagh it's … I never knew what chronic pain was.

S. is trying to get help with chores at home because she has been cautioned about lifting anything heavier than 10lbs, using vibrating equipment like lawnmowers, and riding in boats. It’s hard for her because she was athletic and physically active. Close to the end of the interview S. tells me about a copy of a letter she has received from her union representative to WorkSafe BC, providing input on her appeal. In this letter the union is expressing confusion with respect to why S. didn’t appeal the permanent disability decision if she was still being medically treated. But she tells me she had appealed it when it was calculated at 9.2% of wages. Interestingly the union emailed her asking if she had heard anything about the case they “had won for her,” but she believes the union did nothing. When I remark that she must be feeling manipulated by the union she responds:

Yeah. It was tough to have the doctors … to go through the trouble … struggles with my doctors … me trying to convince them that it's … I believe it's a workplace injury. It seems like it's the same struggles with my employer [right], the union and WorkSafe. That they're not listening they're just doing their process … their due process. I'm hoping things get better. It's so hard to just say, "Screw it," I'll settle with whatever they want to give me just to get them off my back [yeah]. I think a lot of people do that and they end up suffering after that. If they say I'm a quadriplegic, then acknowledge that. I just found out actually in the last couple of weeks … and I did a bladder function test in UBC Hospital and yeah I have a bladder function problem. And they're relating it to my spinal cord injury. It's so hard … yeah I feel like giving up lots.

Dec 13/18 (re-interview with S.)

S. has learned that her appeal has been resolved and is waiting for official letters, which should have arrived at the time of the re-interview. She is unsure at what level her Permanent Disability Award will be set. She learned about this when a different voc rehab person contacted her and informed her she didn’t have to look for work, including locally where there is nothing available that is suitable. Also, she is unable to work full time, so a recommendation has been put forward on her behalf by this new voc rehab person (who S. met with in PG) to the Permanent Disability Award department. Interestingly, S. was “allowed to” email this person, and typically WorkSafe BC doesn’t allow emails from beneficiaries. S. sent this voc rehab person emails from her employer and the union, both organizations being unsupportive.

My employer said they were going to stop working because of this appeal and my union told me I was going to lose, so I had no one to help me through this process.

The previous voc rehab person had informed S. that she wouldn’t work with her because of the appeal. While in appeal, S. was expected to be looking for work and providing proof of the job search, including 3 possible employers a day. It’s unclear how she learned this because S. says no one told her about this policy. She understood that voc rehab meant retraining so she focused on work she could be retrained in. S. did apply for jobs locally which she didn’t get, including running for Band council.

Her 90% wage loss benefit has been reinstated since May-June when the decision was made she didn’t have to relocate for work. She has been told that the money lost when they decided to cut back her benefit would be figured out in the Permanent Disability Award, but she should get it back. S. has been told that she her voc rehab person is recommending a full pension, but doesn’t know what that means. She remains distrustful of WorkSafe BC though, and unsure what calculation will be used, telling me

I'll be stuck in the position of needing to find somebody to help look at it to make sure they're not really ripping me off.

While she was in appeal, which has lasted over a year (she refers to it as torture), her Permanent Disability Award was set at 32%($1600/month) and she couldn’t make payments on the new truck she bought to accommodate her injury. S. had one of her credit cards cancelled—another credit card company was more understanding because she had had the card for 30 years. Since the reinstatement she has been able to make her truck payments but is not caught up yet. Currently that award is topped up to 90% of her previous wage as part of the voc rehab process (she thinks). She pays no rent because her home belongs to the First Nations band she belongs to. She assumes responsibility for the utilities and repairs. Moving to another location to work would mean she would also have to begin paying rent, something she is not sure WorkSafe BC understood, or accounted for.

S. continues to have bulging discs (C5-C6) and ongoing symptoms, which she accepts as permanent, but tough to manage. She finds she is exhausted and sore if she does too much

I get really super duper tired and my body aches and I just want to lay down [uh huh] and that feeling of dragging your body around hasn't gone away. It just feels like I'm forcing myself to move my body.

I asked her about help in the home and she tells me that WorkSafe just made a decision about the that. S. receives $300+ monthly, which she believes is the maximum allowable for domestic chores. S. says that she was told that when this was approved she spoke to the voc rehab person who told her she is eligible because she is over 75% disabled, even though that the Permanent Disability Award percentage is still being calculated. S. uses this money to pay for help with getting wood in, mowing the lawn and shovelling snow. She remarks that the folks in voc rehab at WorkSafe BC didn’t seem to understand that if she did get a job, she would need to get help to shovel out her driveway early, on the mornings when it snowed, something she figures is unlikely to happen. We talked about the new range of benefits she may receive if she is deemed to be more than 75% disabled. S. claimed to not know what these were, but did mention that she had asked for medication support in the past, and she had to be a certain percentage disabled to get those paid for by WorkSafe. The meds she refers to are: nabalone (cannabinoid/analgesic) and venlafaxine (antidepressant), both being partly paid by her previous employment-based extended medical benefits currently. She is also taking Lyrica (treats nerve pain). She’s not convinced the meds she is on are effective:

Some days I feel like … aah oh my god I'm plugged into an electrical outlet and the medications doing nothing. I haven't really stopped taking medications since my surgery, so I don't know how bad it would be if I didn't take those medications.

If she is eligible for the expanded benefits because of being deemed more that 75% disabled, then she hopes WorkSafe BC will pay to replace her back steps with a ramp; she heats with wood and bringing in wood is difficult. She would also like her bathroom made more accessible. About two years ago, WorkSafeBC sent out an occupational therapist (twice) to assess her home for modifications. This OT made recommendations to WorkSafeBC, which S. told me were ignored. She wonders about what is allowed or not; she once asked for a treadmill because she couldn’t walk on uneven ground, and was told they didn’t provide these kinds of benefits, but maybe would after her surgery, which didn’t happen.

When I ask her if she is feeling like she wants to work, she replies:

I feel too exhausted most of the time. I really feel too exhausted. You know my girls are going to be here [she has three daughters] and they always want to do stuff. And it's like I'm excluded from a lot of the things we used to do now. haven't gone skiing for 3 years, since my injury. I makes it tough because one of our things was —and still is— going skiing for one or two days during the Christmas season.

S. was in Vancouver earlier in the fall seeing a specialist who does work for WorkSafeBC, a neurologist, Dr. T., who told S. that all her aches and pains could be related to her injury. She tells me she has seen at least six of their doctors, among who are specialists who say she is not capable of doing a full-time job. She is relieved that she doesn’t have to fight any more, but says

It's a relief but it’s like, "Oh my god what are they going to do next?" Because it is uncertain. They don't tell you much. And it would be great if they do something before Christmas so I can have … like last year I didn't buy any Christmas presents and I really couldn't afford it .[yeah] That was tough. I've never gone through a Christmas like that before.

S. is going again to Vancouver to have her kidneys looked at because she has a bladder function condition related to the spinal cord injury. She also complains of a dull ache on the right side near her hip—she suspects she is out of alignment. Also, her left ankle gets really sore when walking, especially so that she begins limping right away, and balance is an issue especially when she’s tired.

## **ICBC Participant Narrative**

K. is a young woman in her twenties recruited for the study through the regional Acquired Brain Injury Society. She lives with her boyfriend A. in a modest, newly-built townhouse close to the downtown core of the city in which she resides. A. is unexpectedly present during the in-person interview, and fills in gaps when K.’s memory is not clear. I pick up that he is frustrated with ICBC and the process of obtaining benefits for K. She is emotionally vulnerable during the interview, aspects of which trigger difficult emotions for her.

In the fall of 2015, K. was riding her bike home from the university she attends when a car turning left entered the intersection K. was crossing (legally), and hit her directly on the side. She tells me, “My helmet hit the ground so my brain was shook around in there and things have been confusing ever since.” A witness to the accident called 911, but the woman whose car had hit K. ran out, grabbed her and tried to pull her to the side of the road. K. remembers “being like ‘no, no, no! If there's something wrong with my neck I shouldn't be moved at all.’ I remember being like (more emphatically) ‘No, no, no!’ But she like pulled me over to the side and then she was like cradling me and like ‘Sorry, sorry, sorry, sorry.’ ” An ambulance attended and walked K. over to the ambulance, asking her if she wanted to go to the hospital — she had scraped elbows and knees but the ambulance attendants thought she “looked fine.” Given she was late for dinner, and had a brain injury, she tells me she “wasn't making the right judgements or … I was confused and everything. So then the cops took my bike and put it in the back of their truck and drove me home. And then …um … the next day I went to the doctor.”

Not having a regular physician, K. saw a doctor at the university student health services who tells her she seems fine and to go home. A friend visiting that day asked if the doctor had checked her for concussion, so K. went again to the same doctor and requested a test for concussion. The doctor asserted he had done a test, which K. didn’t remember — “He said ‘I asked you if you had passed out … if you were unconscious.’ Well if I was unconscious how would I know it? And he's like, ‘Well you wouldn’t!' Then he kinda did this finger thing with me and then he's like, ‘Yeah it seems like you have a concussion. Don't go to class for the next couple of weeks and see how you do. Come back in two weeks.’ And then it just got worse.”

Her boyfriend works full time; after the accident K. was home by herself, not being able to do very much. A. would ask her in the morning what kind of tea she would like. K. could picture the tea shelf and the collection of tea but was incapable of deciding. This was incredibly stressful and confusing for her, and she spent a lot of her day crying, and in pain from headaches. When she tells me this her emotions surface. At the time they lived in a suite underneath the landlord, who had a young child who rolled some kind of device incessantly across the floor —the persistent, loud noise contributed greatly to her symptoms. K. wasn’t able to verbalize at the time what exactly was bothering her and only later learned at the Acquired Brain Injury Society that sensitivity to noise is a symptom resulting from brain injury. She remembers being very uncharacteristically irritable and quick to anger, screaming “STOP” at the child.

K. remembers feeling this way for about five months, until March 2016. In March she and her boyfriend went to Mexico on vacation, which by and large she found difficult, in particular travelling there and back, and being overstimulated by all the people and sounds, which left her exhausted and emotionally upset by the end of the day, even though she would wear earplugs for meals at the all-inclusive resort they stayed at. This accommodation suited her because she hadn’t been able to cook for herself and could just choose from a buffet what to eat; in fact, she was having difficulty meeting her nutritional needs at home because she would open the fridge at home and nothing would look familiar. Sometimes A. would leave leftovers in the fridge for her and she would know they were for her to eat, but “sometimes I would just be like ‘I don't know what to do’ so I just wouldn't eat at all.”

Our conversation bounces around a bit because of K.’s memory issues and cognitive impairment, which prompts her to remember related aspects of her experience instead of responding directly to the question. This kind of free association happened throughout the interview.

When I ask about when a claim with ICBC might have begun she tells me about her experience with the university as a result of the injury. She was unable to complete final projects that fall and was instructed by the university to defer her classes to what she anticipated would be the second semester in January 2016. When I asked if she was on a leave from university or going to classes, she responds:

Well I tried to go back to school last September in 2017. My occupational therapist wanted me to audit one class just to see how I would do in the classroom situation and get used to all the distractions and all of the focusing issues and memory and everything. But (names university) said that because my classes that I deferred … I never like came back to them and came back and did them … like I wasn't under the impression that that was something you had to do. I was SO out of it I didn't even know what I was doing [uh huh]. So they were like "Oh well those classes count as zeros, so you're not allowed to be in our institution. You have to go to (names a local community college) and like bring your average up enough.’ And I'm like "What are you talking about? I don't have zero marks." But then I had to go through all this bureaucratic stuff and tell them I had extenuating circumstances.

When I ask if she had informed the university that she had a disability, she recounts that she had been hit by a car and was brain injured, but curiously tells me that “the Canadian government” wouldn’t let her say she was disabled because she applied for welfare [I think she means PWD here], and they informed her she was ineligible because her brain injury was improving such that she would be able to get work, a reason K. apparently believed and accepted. At the time of the interview she has been out of school and work (she had a part-time job while attending university) for 2 years, and was still unable to work at the time of the interview.

When I ask again about applying for ICBC, A. responds, telling me that a claim would have been filed right away because K. had an injury sustained in an MVA. An ICBC adjuster was assigned to her case. Interestingly, she and A. hired a lawyer right away because A. had also been hit by a car on his bike previously and worked with “bike lawyers,” so knew what to do. Right away, the lawyer (or legal firm) switched the adjuster with ICBC to one they had previously worked with. The lawyers informed K. that nothing would happen until 2 years after the injury, especially with brain injury because it is different for each person. K. continues to submit receipts for medical expenses to the lawyer, e.g., medications, occupational therapy. Almost right away, within a couple of weeks of the accident ICBC suggested K. see an OT (paid for by ICBC) because she was having trouble with activities of daily living — she couldn’t prepare food, clean, or even choose what clothes to wear. It’s not clear how this recommendation was communicated to K. because she tells me she has never spoken to the adjuster. In fact ,the lawyer instructed K. not to talk to ICBC at all, and in some cases the OT is the intermediary, for example, K. currently needs 3 more months at the gym, so the OT “talks to ICBC and makes it happen.”

I ask about any other services she receives that she doesn’t have to pay for (and presumably ICBC pays for) and she tells me

Well in the beginning they were paying for Comfort Keepers to come over. It was a person who came over and they just did whatever I needed. So sometimes I'll be like “(names boyfriend) has is going to work late tonight I need dinner" so they would like … I would give them like a recipe and then they would just do it. And I feel like I have no clean clothes so they do my laundry. Or I wasn't like able to clean anything so they would do like cleaning around the house, and sometimes they would just sit with me and talk and hang out yeah.

The service was initiated by the OT who had worked with this private sector company previously. He approached ICBC informing them that K. needed this kind of help; ICBC approved this request and contracted (and paid for) these services. Apparently, a worker would come once a week for about 1.5 hours. Unfortunately, a different worker would come each week, which K. found exhausting, mostly because she had to write out the tasks, which might vary from week to week, and show each different person what had to be done. This service discontinued services after 8 or 9 months when K. expressed the need for help with cleaning, which Comfort Keepers did not do.

Eventually, K. & A. found a cleaner, who was paid through the lawyer. Also a taxi fund was set up through ICBC for K., who couldn’t independently use public transit, drive or ride her bike. ICBC also assigned a life skills worker to K., and one of her tasks was to help K. learn to take the bus, so she wouldn’t need cab service anymore. The ICBC cab lasted over a year; life skills workers continue to visit. Early on these workers helped K. to stay focused while cooking, answering emails, and dealing with the university administration. She often gets distracted and forgets what she is doing, especially while cooking so the worker walks her through the steps and assists her. K. admits that even standing and chopping veggies exhausted her, something she only recognized when it was pointed out by the worker.

About a month ago she discovered from her pharmacist her meds could be wholly subsidized through “Plan G.” K. qualifies for this BC government psychiatric medication plan because she is taking an approved anti-depression drug. Her life skills worker also helped K. apply for welfare at the beginning, and when she was denied she applied for PWD. She was not eligible for either benefit as she recalls:

And I remember just being like "I have no money like I need to pay rent. What am I supposed to do?” It was is super-fucking stressful (tears up/is upset). [yeah] So we applied for that and basically they sent back a thing that was like "because you're steadily improving every month" — like every month I was able to do something that I couldn't do before but it's like su-u-u-per slow [uh huh] but they basically denied me that, and then I applied for like PWD and they're like, "No, you're slightly getting better so we're not going to give you anything."

And I applied for CPP-D … that was the first time with the first life-skills worker and that got denied and then we had to wait 3 months to apply again, and by that time I was with the Brain Injury Society. I had a case manager and so she went through the paperwork with me over like …  like I met with her once a week and we worked on it and it took like another couple months or something to fill out the paperwork. But then we sent that in and they had to wait months and months, and I just got it [the second application] back like a month ago or so and it was like "Yeah. No we're not giving you anything."

K. doesn’t remember much about who completed the PWD application form but suspects it was the GP she saw at the university health services. When I inform her she can apply again and would discuss this with her after the interview she begins to cry and tells me:

Just my PTSD symptoms. My body just cries now. [mmm]

R: Is there something about what we're doing triggering that?

Yeah.

R: Tell me what it is if you can.

Just thinking about the people who weren't able to help because the life skills worker at the beginning was really incompetent but I wasn't able to tell that she was. I wasn't until like months and months of being with her where (names boyfriend) was like "She didn't do that! We shouldn't be working with this person. Like she doesn't have your best interests at heart."

R: And what kinds of things was she doing or not doing that were upsetting?

(crying) Like when we started to learn how to go back on the bus, she was like, "OK so we need money to get on the bus and we'll look up the times." And so we went out and waited, then we got there and she didn't have the right amount of money. And I was like "You should have known this. I was relying on you to know this." And then I started like having a panic attack on the bus and it was just a really negative experience.

This worker (contracted by ICBC) was often late and even spent once visit playing Pokemon Go with K., and not focusing on the other tasks she was there for.

At the time of the accident K. was also working part-time, about 10 hours weekly, and also had a student loan. The lawyers informed her that ICBC would pay K. disability benefits (Total Disability Benefits) in an amount equal to her employment income (approximately $120 weekly) in twice yearly lump sums. She has recently learned through the lawyers that ICBC is likely to discontinue these payments soon, which leaves K. feeling defeated. Interestingly, the legal firm has offered to lend her money but would charge interest on that loan, which she has refused. K. was unaware that she has been repaying her student loans via automatic bank transfer and when she discovered it, with the help of the life skills worker, she was recently able to undertake the administrative process to have these payments deferred. This required securing forms, a doctor’s visit to complete the forms and sign them, and submit them to the university.

[At this point K completely loses her train of thought or the topic we are addressing in response to a question I ask about possibly appealing the ICBC decision to terminate the Total Disability Benefit payments. She has an appointment tomorrow with the lawyers and makes a mental note to request they contest this decision with ICBC.]

K. believes momentum has picked up with her case, in that the lawyers have her meeting with a specialist they have chosen, and ICBC also wants her to meet with their specialist. She attributes it to “the 2 year mark” at which point the statute for an injured party to file a lawsuit with ICBC expires. On the advice of the lawyers, K. waited until late in 2017 to do so. Both specialist appointments had been scheduled at the time of the interview.

[Interestingly, I learn later that the specialist in Vancouver — a psychiatrist apparently — has come under considerable media scrutiny for being the highest billing specialist with ICBC. I don’t think K. is aware that the Vancouver specialist is not a neurologist.]

K. reveals that she is working with In Focus (employment program)[see:<http://infocusservices.com/employment-program-of-bc/eligibility/>] to see if she might be able to get back to work, and has to go through all their processes before meeting with someone who would assist her to figure out what job would work best for her, even though she is unsure of being able to work. K. had tried last semester to audit university classes which was for her part of trying to figure out whether she should try returning to university or try working first. Unfortunately, due to large class sizes her auditing status wasn’t viable. Also, sitting by open windows with university staff noisily doing yard work, and alternately moving closer to the door where students were coming in late and checking cell messages were too distracting. In addition, her medication makes her sleep in until 0900, so early classes are out. Interestingly, ICBC paid for the purchase of a back rest to take to school with her because of the uncomfortable little classroom chairs, but was fatigued by the time she got to class.

Also, when she received a leave from the university she could no longer use the university health services, she had to find a new doctor in community. The one she found was “really new” and K. believes this might be part of why her CPP-D application was unsuccessful the second time.

Below is the text of an email from me following up on unfinished aspects of her ICBC claim.

Nov 14/18

Hi K. —

I hope your health has improved since our interview in the spring.

I’ve finally transcribed all my research interviews and created narratives from each one, in order to paint a picture of each person’s experience of applying for and living on the different benefits each receives.

I have a few questions for you, which we can chat about via phone or Skype. Or, if it is more convenient and you have time, you might be willing to answer the questions in an email. Alternately, I can come by again and interview you in person, if that is your preference.

Mostly I just want to follow up with where we left off. At the time of our interview you were still waiting for a decision from ICBC about a settlement in your case. You also mentioned that ICBC was likely to discontinue your Total Disability Benefit payments soon. We talked about you meeting with a specialist in Vancouver that ICBC had chosen and also one your lawyers had chosen, given the approaching 2 year mark for filing a lawsuit with ICBC. You also spoke about working with In Focus to see if you might be able to go back to work, but you seemed uncertain whether you were able to work (or attend university).

My questions focus on these issues, more or less unresolved at the time of our interview.

1. Did ICBC discontinue your Total Disability Benefit payments, and if so, when? What was the reason given for doing so?

2. Did you meet with the specialist your lawyer recommended? The ICBC specialist in Vancouver? What was the outcome of these appointments? Did these two specialists concur regarding your abilities/disabilities?

3. Was a lawsuit filed with ICBC within the two year statute of limitations? What were you suing for? (i.e., terms of a settlement) Have you been successful with this lawsuit, or is it still in process? Were you at any time advised to take a settlement that is unsatisfactory to you?

4. Did you continue (or are you continuing) to work with In Focus? Or did you decide to try again to pursue your degree at UVic? I f the latter, were you able to get the kind of accommodation you need to do so?

Please let me know if it is better for us to discuss these questions via phone or Skype or in person, and if so we can schedule another, likely pretty short appointment, so as not to take too much of your time.

Otherwise I look forward to your responses via email.

Thanks again K. I really do appreciate your willingness to share your experience as part of our research project.

wishing you well,

Sally

Dec 4/18

Hi sally

Thanks for your patience. I have the answers to some questions, and others I am waiting to hear back from my lawyer.

1) waiting for response from my lawyer

2) no, I did not meet with the specialist because my appt was cancelled. I have a tentative appt booked with the same type of dr but in Nanaimo instead of Vancouver.

3) yes a lawsuit was filed within the 2 year period. Waiting from lawyer to know what we are suing for. It is still in process. There were no settlements offered, as far as I know.

4) no I did not continue to work with in focus. They couldn’t find appropriate employment that met my employment criteria. He said I had too many limitations. I did find a job that meets all my requirements, working with a friend at her home business. I decided to do a class at the Pacific Design Academy instead of university. They are cool with M. (her dog) coming to class, and it is a small class of 6 students so I have ample opportunity to ask the teacher questions and make sure I understand correctly.

As soon as I hear back from my lawyer, I will fill you in with the other answers.

Thanks sally

K.

## **LTD—BCPVPA (BC Principals and Vice-Principals) Participant Narrative**

The interview was conducted via Skype; M., a middle-aged woman who lives with Multiple Sclerosis is seen lying down throughout the interview. She lives in a mid-sized B.C. city with her husband, who she later reveals has esophageal cancer, and their dogs, in their own home.

The onset of the illness was sudden and rapid; on Labour Day 2008 M. got “these weird feelings in my legs that by the Thursday led to me being in hospital.” Before going to hospital it took her a few days to work out what was happening. She was a school principal in the public education system in BC. That week at work she couldn’t walk as well as others, or keep up with them. On the day of her hospital admission she called the BC Nurse Line and a nurse went through a flow chart with H., and concluded she needed to see a doctor immediately (that day). She was sent to the hospital from a local walk-in clinic she attended; an MRI was done and she was diagnosed with transverse myelitis, which later became MS. She was sent home after four days in hospital because “there’s nothing they can do for you, you know, it’s, ‘You’ve got it. Go home’ sort of thing.” Subsequently, in the short term she was never able to work more than two days at a time.

In her entire working life M. had never been off sick. Beyond knowing she had accumulated sick days, her understanding of the benefits aspect of her employment contract was limited, mostly because she didn’t think she was going to use them, being a healthy employee. The concept of long-term disability (LTD) was also completely foreign to her, apparently being non-existent in England, from which she had emigrated eleven years previously. It was a highly confusing time for her:

So I was in a complete sort of not knowing, and not knowing where to concentrate my attention — on my disease, my disability, because my MS … as I said it's not normal to get symptoms on a Monday and be hospitalized by Thursday, and not have had previous symptoms, and so on. Everything that was happening was so out of the loop and it was the first week back at school and everything! So you just don't know where to focus your attention.

M. had an early conversation with her neurologist in which she claimed that she didn’t know what she needed to do to be sick in Canada, and figured she needed a sick note for her employer. In requesting it, she said, “Well I guess all of this sounds quite serious … I'll have a week off full-time, and then I’ll go back part-time after that, and just get myself back into it … and that would be it after a couple of weeks. I'll be back at work. I'll be fine." The neurologist wrote “with doctor’s permission” on the bottom of the note, which ended up being limited as she bargained with him to return to work maybe two or three days weekly, providing she slept an hour at lunchtime. Interestingly she didn’t know who the note might be for, which was part of her sense of not knowing what she was doing at this point and who to talk to. No one was telling her. M. ended up giving the note to the head of human resources for the school district, who thanked her for it, but didn’t provide her with information about how to proceed going forward.

M. didn’t return to work until late October, although she ended up spending hours before returning responding to emails and on the phone with the substitute principal to “keep my school running on the path that I wanted it to run. So it was almost like I was trying to run the school by remote, right?” After M. returned to work, until the following February (2009) she and the substitute principal basically job-shared at M.’s school, with M. going in two days weekly. By February, the hour-long nap at noon was “happening earlier and earlier, and the final day I worked — by 10 a.m. — I needed sleep. So I basically said, ‘OK this is it. I'm done’.” Her family and medical people confessed they had been waiting for her to come to this realization on her own, because they knew they couldn’t tell her she shouldn’t be working.

At the point of going on disability leave, M. discovered she had exhausted her sick days and was told by the school district Human Resources office that the LTD application could take a couple of months — it hadn’t been submitted at this point. The staff in this office would respond to M.’s questions about LTD in sympathetic ways — “Don’t worry, we’ll take care of you.” But what she really needed was someone to sit down and explain the whole thing to her. It was the BC Principals and Vice Principals Association (BCPVPA) LTD program, so M. also had to speak to people from that organization, who revealed that the school district should have sent the LTD application in September when she was first off work. This news, and the possibility that she would have no income for months during the waiting period sent her into a “deeper tailspin,” not an insignificant effect living with an auto-immune condition affected by stress.

Financially, M. earned the primary income for her household — her husband had a small business that produced a secondary income. M. approached the school district about this difficulty with some trepidation, “you feel … you know you're sort of beholden to people and you're in a bit of dance almost [uh huh] … and I say to them, "What's going on?" And they said, "Don't worry we'll take care of you. What we will do is we will just keep on paying you until the LTD kicks in, and then there will be a reconciliation.” She is unsure if someone in the school district dropped a ball initially or this was how they routinely approached LTD for principals, who were in a different benefit category and program than teachers and other staff. Ostensibly, M.’s sick days served as her short-term disability leave. Upon reflection, she considers this approach of “don’t worry we’ll take care of you” as somewhat parochial, and perhaps patriarchal [does she mean paternalistic?], while recognizing her relative privilege as a principal: “It's sort of pat you on the head and take care of you. But I mean for all that those things caused me stress, it was wonderful right? [yeah] They did take good care of me because of the privilege of the position that I was in.”

M. began the LTD application process, including asking her family doctor to complete forms, “And that's when you really start to realize that you're in quite a different process now. [uh huh] And that is stressful and scary in itself.”

I ask her what was stressful and scary for her.

Because so much about my disease is unknown right? [uh huh] So a lot of the things you describe in "soft" terms, like fatigue and particularly in those earlier days a lot of the expectations around MS are … are you going to get better? Right? And when you talk to people, particularly within the MS community the number of people that get refused for their long-term disability and that sort of thing is really high. And I was still trying to learn … 'cause I was only like six, seven months into my disease I was still trying to learn about my disease and where I sort of fit into … again because mine was aggressive and advanced and a little bit unusual, the things that people were telling me including the neurologist that I had here locally I was a bit outside their experience. So my GP doesn't get many people with MS so therefore not many like me. So up until then you know when you're dealing with doctors it's all full of … you're trying to talk about hope and it could all go away again. But then when you fill these forms in, how do you communicate these things? So you fill your own part in. So there's also a part where you sort of have to suspend hope for a little bit as well. You really have to deal with the reality of what life looks for you at a time when you really want to focus on trying to get well. [uh huh] Fast forward ten years—that's not happened right? [yeah] But at the time you don't know that. So the forms don't fit something that's episodic, don't fit something that's changing, they're pretty rigid, right? [uh huh] And you're putting your financial security in the hands of your GP as well … wonderful woman, have a great relationship with her, but will she … does she get the severity of it? For the small time we've spent together does she … how can she understand the impact on my daily life? [uh huh] And it's all new to you. It's all completely new and you haven't heard anybody say, "Oh I have this wonderful relationship with my insurance company, all you hear is horror stories.”

M.’s LTD benefit began in May (2009) when she received a cheque from the insurance company (Sun Life at the time, currently ManuLife) for about $10,000 back-dated to the beginning of September, of which she had to repay $8,000 to the school district immediately to cover wages and benefits during the period she was receiving full salary. The school district also paid M.’s extended health and dental benefit premiums until the end of that school year. She has since paid her own premiums, including MSP premiums, about $200 monthly from her LTD benefit. Her indexed LTD benefit, calculated as 60% of her salary at the time of disablement, is not subject to income tax, which she found disconcerting completing her CRA return at first and entering zero for her income. The school district continues to pay M.’s employer-sponsored life insurance premiums ($30/monthly) until retirement. Interestingly when her LTD benefit ends at retirement, M.’s retirement pension is subject to income tax, so she becomes a taxpayer again. She is well informed about the transition between LTD and retirement, which she reveals after I ask her if she is accruing years of pensionable service while on LTD.

Yes. I am.

R: OK. So you'll have a full pension when you retire?

Yes. So what they do is put me in touch with this, that, and the other from Sun Life, and they did a calculation of when I will switch … 'cause basically what they want to do, understandably, is that the insurance company they're looking for ways that they can pay out less money so they want to get you off their books as soon as they can. So they get in touch with the teacher’s … ’cause even though you're a principal, you're on the teachers' pension plan. And they get in touch with the teachers' pension plan and they work out the calculation as to when is the earliest when you can retire on full pension. And that was worked out to me to be at 62. And so at that point things will start to switch, which then the benefits and extended health and all of that will … I'm already starting to work out when I shall have my next wheelchair and that sort of thing. Get it all done before I retire, right? [yeah] It all becomes another load of complications.”

M. reveals how important it is to plan for retirement in ways non-disabled people rarely have to consider, that is, to ensure the expensive device she needs to be mobile — her wheelchair — currently subsidized as part of her benefit plan, will need to be purchased or upgraded before she retires, so she can afford it. And she uses the information about when she can retire on a full pension to her advantage with respect to planning around this large expense.

I ask M. about applying for CPP-D, a typical requirement of employer-sponsored LTD plans, and she reveals that she was developing quite a good relationship with her claims person at Sun Life, with whom she began discussing this. Medical reports were going every six months in the first year to Sun Life, then yearly.

I just said to him, "I don't understand. You're going to have to explain it to me, right? This concept is so foreign to me because … being British and all the rest of it we're just going to have to go slowly and explain it to me." So he said to me that "we will ask you to apply for CPP-D, but we will not ask you to apply until we think you're going to be successful." Because it's not in their best interests for me to be unsuccessful. They want me to be successful so again they can stop paying that amount of money, right? So he … I think in the first year he got six months reports—medical reports—sort of thing and so he said right at this point "We think we should apply" and I'm going to say that was probably another year later.

M. is now well versed in the LTD policy and how the “own job” definition of disability changes after a certain number of years, in her case 5 years, to any job commensurate with her education and experience. From her contacts in the MS community, she has heard that it is much harder to successfully apply for CPP-D than LTD. She was successful applying for CPP-D the first time, which surprised her greatly.

R: And were you successful the first time …when you applied?

Yeah. I was. Not only that but within six weeks, which was rapid. So I got this phone call and it was somebody from CPP-D. I was very surprised I got this phone call after six weeks and my heart dropped and I came into my bedroom with the phone, expecting to be … I was like "Here we go—this is where it begins." And it's like (imitating CPP-D person on phone) "Hi there Mrs. — I'm ringing to say that we've approved your benefits. And I said, "Pardon? You've done what?! "(laughs) And then I said “Well thank you." And she burst out laughing and said, "I've never had anybody thank me before" (laughing) … I mean I go to bed from 12 to 5 right? That's certainly not conducive to going to work or … She said, "Yeah your case is one of the clearest I've seen." So I still think I just got them all on a good day because people that I've seen and heard have had much, much more difficult times of things than I've had. So then what happened is that that money came off my LTD so now I get two cheques a month.”

Throughout, M. recognizes her relative privilege compared to other disabled people, in particular those on PWD benefits. Nonetheless, she also laments how she missed out on a wage parity claim made by her colleagues after she became ill, that she couldn’t take advantage of, signalling the discriminatory nature of LTD policy tied to wages at the time of disablement. Her LTD benefit is enough to support both her and her husband who is now her primary caregiver, which she believes is a privileged position. Some of her acknowledged privilege is related to being well educated. For example, M. has taken the lead in creating a national online MS support group, informal networks of support to discuss treatments, experiences and benefit plans. She is also involved in more formal advocacy, sitting on the board a provincial disability advocacy organization, has been taking online courses in Disability Studies, and is considering pursuing a PhD. These activities are not without challenges:

…and then my sort of more formal advocacy stuff … you know that I've been doing. Which creates other concerns in myself and challenges that … you know … if my LTD company realized what I spend my waking hours doing. So do they now think I'm more capable? Would they understand, for example, that I'm giving this interview to you in bed? Because that's the best way for me to stay with it to be able to talk to you.

R: They're not going to know about it so …

No but you know what I mean. I have talked with a friend about education and the courses that I want to take and how I make that look so it's acceptable to the … and I thought, you know for my own sanity I'm going to get in touch with my guy from years back and say, "Hey! Can I take a course? And he said, "Well have you already taken them?" And I said, "Yeah, just one a semester." "Are you teaching?" " No, nope, nope, not teaching." "We would be fine with you taking one course a semester."

R: Perfect.

So one course a semester. It doesn't matter … you know … they don't have to know what level it is. But again it's … you constantly exist on … you know … what if this whole support mechanism goes away?

R: Right. And so in a sense … it's a kind of chain and umbilical cord. That idea that at one level looking over your shoulder all the time [absolutely] and on the other hand it's providing you with an income that's allowing you — in your case — to have a fairly privileged life compared to others with disabilities.

Absolutely. But without doing these other things, you don't retain the mental stimulation … what do I do? Spend my life watching TV and reading novels? That's not me. That's not who I am or was and that's not realistic, right? [yeah] I've never been directed towards any rehab. I don't have a rehab person, and I've never been asked to declare anything like that right? [uh huh] It's "don't ask, don't tell." So I did ask because I sort of wanted to get it on the record that a course a semester was fine, right?

Although she is taking one course per semester to test her stamina, M. does worry that if she requests accommodation at the university that the forms completed by her doctor become part of her medical record that the insurance company can request at any time. She is also concerned about different aspects of doing a PhD should she pursue one, while retaining benefits and what might be allowed. For example, she knows she would not apply for any grants or work as a research assistant. Her mother wonders sometimes if she should be sharing personal information on Facebook or her blog that might be read by the insurance company. She reads accounts in British papers of disabled people being surveilled and having benefits disallowed and considers it to be “a very big part of all of this is that you're really passing over this control onto somebody else.”

 Interestingly, a recent basement flood put it all into perspective for M., when the insurance company informed her and her husband they could work off their deductible by putting in time cleaning up the damage before rebuilding. As she says, "who would have thought home insurance would have been … and for water damage and everything … would have been easy, totally stress-free in comparison” to dealing with the insurance company that administers her LTD claim.

Nonetheless, M. also recognizes the importance of keeping an accurate paper trail, including everything her doctor has submitted to the insurance company and copies of test results. She returned to her neurologist, who she finally let go of, to point out inaccuracies in reports he had written emphasizing their importance:

Not only is that part of my medical record, but it's part of my financial record right? [yeah] Everything has a double meaning to it.

R: Meaning that if you have a test it could impact your income right? Or if you don't have a test, or whatever? Or the outcome of a test?

Yeah! And also there's this box on there [yearly review form] that says … "Are they following the recommended treatment?" And that basically told me, rightly or wrongly, that if I wanted to get paid I needed to do what my doctors were telling me, right? [yeah] And there was one drug in particular quite early on within the first year, I really didn't want to take because the research is really … people have become extremely disabled on it, people have died … so if I say no to that, does that box get ticked?

R: It's scary.

Yeah! And I still don't quite understand the answer to that but … I have a different neurologist that I have a great relationship with and I don't have those sorts of fears anymore. But again that relationship with that first neurologist was pretty fraught and you know … in those early days when all those forms are being filled in, that's really stressful, right?

R: And has the potential to exacerbate your condition.

Absolutely!! Absolutely. I mean there was stress coming in from every angle … you see this neurologist and him writing that I had an EEG and that  he results were normal and I had never even had the test right? I mean things like this. Yeah, I mean I would literally go back to him with a report and correct it line by line.

M. was also asked to provide a medical note yearly to the school district signed by her doctor stating she was still not capable of working, which she experienced as another level of surveillance. But a colleague had become director of HR at the school district, so she approached him about having to submit this note yearly, suggesting it was a “silly” practice and should be permanently waived, to which he agreed. M. considers this an effect of her privilege. She understands that she has to remain an employee of the school district in order to receive LTD, and even though this bureaucratic requirement has been waived, M. is aware that if she were an extremely outspoken advocate it might have repercussions with her LTD — “yep, I still have to behave as a school district employee.” When she tells me that she has eleven more years to retirement before she can be free of all this she says: “It's certainly an interesting dance that you're leading all the time [yes] … to say that fear in your mind … and whether the fears are founded or not, right? But it doesn't really matter, if you still feel it.”

We have a short conversation about Choices in Support of Independent Living (CISIL), and again she points out her relative privilege, as she recounts a story about another woman living with MS who is quadriplegic and receives home support from the regional health authority. Apparently, this woman is reviewed annually and part of the review is having a case manager time her doing particular activities of daily living to make sure she’s not misrepresenting her disability. The activity that is being timed is her showering. M. remarks that if this was required of her she would be assertive and ask them to leave. The health authority has only asked to watch her transfer (she is non-weight bearing), and since the first time declined to ask again.

M. is on the CISIL home support program, and has been working on a political campaign with another advocate in BC (also on CISIL) regarding how this provincial program is structured and delivered. Without getting into the minutiae of the program, M. needed some changes to be made to meet her “payroll” (she hires workers & pays them using funds from the health authority earmarked for home support). Her request had to go to a committee and was being deferred. Her case manager was asking to present the details to the committee to hopefully expedite M.’s case. M. expressed a strong desire to speak to the committee on her own behalf but was flatly refused. She points out the irony of this decision with respect to the title of the program, in particular the word independent’: “if you're going to make something that's independent you at least have to allow the people to participate fully in the process. So yeah it's very interesting that the 'I' only means Independent when they want it to.”

## **LTD—BC Teacher’s Federation SIP Participant Narrative**

Our interview was conducted by phone. E. lives alone part-time in the lower mainland of B.C., and also spends time living with her boyfriend in Calgary. She owns her own home in the B.C. lower mainland. Her benefits are portable, i.e., there is no stipulation that she remains in B.C. If there was she tells me she would not reside elsewhere.

In 2011, while continuing to work, she obtained a Masters of Science in Educational Methodology from the University of Oregon, a more research-based degree than an M.Ed. . E. had been teaching nine years as an alternate education teacher at the high school level (Gr 10, 11, 12) at the time of disablement. Her students were at-risk kids — she found it demanding, but rewarding work. She took a leave at some point due to work-related stress (not sure of the date, or length of the leave), and is a bit fuzzy about whether the stress leave overlapped with leaves taken for several knee surgeries due to sports injuries. Knee surgeries were in about 2010. E. developed mononucleosis in Feb 2014, applied for and received Short-Term Disability benefits, and returned to work as part of a Gradual Return to Work in the spring of that year. She can’t remember if she was working at 80% or 100% capacity upon her return to work before the summer break.

E. previously had five surgeries on her knee (meniscus + ACL repairs) — the latter two done at a private clinic (paid for by BC Medical) to clean up and repair previous “botched” surgeries due to injuries sustained while playing soccer (she went to university on a soccer scholarship). With these surgeries she had considerable experience applying for and receiving Short-Term Disability benefits (administered solely by BCTF) — applying for these benefits was relatively easy, and a voc rehab person at BCTF was helpful to her.

In Sept 2014 BCTF was on strike that month; it was also E.’s last month of working. In late September, she was hospitalized for three weeks because she was fainting, and diagnosed by an internist at that time with chronic fatigue and fibromyalgia. There was some concern about cardiac issues at the time — she saw both cardiologists and internists during the hospitalization. She was diagnosed with mitral valve prolapse and coronary calcification, and supraventricular tachycardia. There was also a suspicion that she might have postural orthostatic tachycardia syndrome (POTS), a form of dysautonomia, secondary to the mononucleosis (this wasn’t diagnosed until 2016 because the lab used for diagnosis hadn’t been set up in Canada/Calgary until then). Her cardiologist in Vancouver sent her to Calgary for testing once it was available. She was subsequently diagnosed with hyperadrenergic POTS. She tells me she has had multiple hospital admissions:

R: And then you were also in the Chilliwack Hospital for two or so weeks, including 4 days in ICU. Is that different? Like I have here diagnosed with SVT at the time.

Yeah. 'Cause that's a totally different thing. I've probably done maybe three or four stints now in the hospital for 2 or 3 weeks at a time.

R: OK. So that Chilliwack hospital admission — I'm not sure what you were doing there. Like why you got there. You told me that you had spent 4 days in ICU at the time.

Yeah. So that was the SVT [diagnosis] and I don't know — like I've been in and out of the hospital every few months since I've had this diagnosis. I had to call the ambulance a few times. So I think maybe the ICU admission probably wasn't until when he fixed me. And then that led to the — I think I had the ablation done in 2016 as well, my most recent ablation.

E. has had two ablations, the first one in 2015 and may have more [ablation] surgery to clean up scar tissue. She had used up her sick days (about 15) in the fall of 2014 when she was hospitalized, and applied to receive Short-Term Disability benefits, thus subscribing to BCTF disability leave policy regarding using up sick time before receiving disability benefits. E. successfully applied for short-term disability leave in the fall of 2014 because of the chronic fatigue. After her Short-Term Disability benefits were exhausted (or close to the end of that 6 month period) she applied for Long Term Disability (LTD) benefits, but was denied initially, and appealed. During the appeal, E. had no income for three months so secured a bank loan to carry her through. Her internist wrote a strong letter to GWL, and included information about litigation that she believes might have been threatening to GWL. She believes this made a difference in terms of her successful appeal, but this was an incredibly stressful period for her, not knowing if she would actually be approved for the benefit and where her income might be coming from.

LTD was approved in early summer 2015. After a year on benefits, the transition from the “own occupation” category to “any occupation” category was very stressful for E. and included a lengthy, detailed form to be completed. It was also completed by her general practitioner. E.’s benefit does not include extended health or dental, so she has declined dental coverage because her teeth are in good shape and she pays out of pocket for cleaning. She understands that she has the option of paying those premiums should she decide to. E. can’t do without extended health benefits (administered by Pacific Blue Cross), mostly for medications. She pays approximately $180 monthly for premiums. E. takes about ten or twelve medications, six or seven of them on a daily basis. Some medications are $100 a month or more. She takes migraine medications that are usually $10 a pill. E. also takes advantage of other modalities as part of her extended benefits package, including acupuncture (ineffective), chiropractic and massage therapist. She also sees a naturopath and uses up the amount allocated to her in a year for those services.

E. doesn’t claim her extended benefit premiums as part of CRA medical expenses because her LTD benefit is non-taxable. Her taxable income is only $12,000 yearly (from CPP-D). She believes that if she had become disabled early in her career that she would not be able to live on a LTD benefit calculated at her initial wage ($38,000 per annum). Her employer pays into her pension fund (and she is accruing years of pensionable service); her employer also pays life insurance premiums on her behalf. She is uncertain what any yearly increases in her BCTF benefit are tied to but believes it is indexed to the cost of living.

E. tells me she feels “taken care of” by GWL now, but didn’t always feel this way, especially in the early days when there was so much uncertainty and fear about not actually getting benefits. Since the transition to “any occupation” she receives yearly review forms from GWL, which both she and her physician must complete. These are generally easy to complete, unlike the more detailed form that she completed as part of the “any occupation” transition. For questions on the form like “Are you following your care plan?” she answers “yes” but offers no further information. Her local BCTF union representative advised E. not to provide any information beyond what is asked for. She does not speak with the union rep very much, more at the beginning because she didn’t know what to do with the application form. She finds the union rep generally helpful.

R: And in general you've found them helpful?

Yeah. (hesitates). They either know the answer or they find it out, of which the latter of the two is most common. And they're able to give me — like regurgitated answers, but it's not like … you could tell that the person does not have any experience going through it.

R: Right. So they kind of know the process or protocol by what they've read or been told but they don't really understand what it's like to actually go through the process, and what you need.

Exactly.

E. believes it would have been more helpful if there had been someone at BCTF who had experience with this process while she was applying for benefits — she felt isolated and alone taking care of this all by herself, and made the point that it’s hardest/most stressful at the beginning when she was sick and didn’t know what was going to happen, that she really needed the help of someone who is familiar with applying. I asked about different ways the union rep might have been helpful.

They were —I would call my local representative when I was doing the forms and if they didn't know they would phone the BCTF office. I also would talk to the short-term disability lady at the BCTF regularly if I had any questions, like she was very accessible. And then when it came to filling out forms in regards to what information I need to divulge to whomever, it was my local representative who said "Simply answer the question yes or no." And "Don't elaborate on any answer." And then when it came time when the district wanted to take back my original job, I had representation in that meeting as well, with HR.

Here E. refers to the fact that the school district keeps her position for two years, and if unable to return to work after the two years then technically speaking they have the right to reassign that assignment. Any time after that if she was able to return to work she would not have an assigned school or position — the district would have to find her one or she would substitute. As she always hoped she would be able to return to work, she tried to hang on as long as possible, and was able to secure a two-year reprieve. E. reluctantly let her position go in the spring of 2018.

After about a year on LTD benefits, GWL mandated that E. apply for CPP-D, which she did. Her father helped her complete those application forms while she was in hospital — she dictated and he wrote down what she said. She was unsuccessful initially, but successful upon appeal. She believes the difference was due to not providing as much information as she could have the first time around, mostly because she didn’t feel great being in hospital. Also, she didn’t understand at the time that GWL was watching her every move because it meant “more money for them” if she was successful, so didn’t care when CPP-D denied her initial application.

I didn't realize that like they [GWL] were even in on all that stuff. So I probably did have that (inaudible) first application just because of circumstances — where I was — and also at the end of the day I was just like you know "Who cares? I'm so sick and tired of doing paperwork for people that … I'm not making any money on this.” It just means I'm being paid two other ways. At the end of the day my payment was the same. So that was my mentality. And I didn't realize that GWL was getting information from them that I did get the denial and all that kind of stuff. Which I get now. Obviously, I just didn't think through it at the time. So, in the appeal I did a letter and I gave them more details than I initially gave them and that was enough.

E. was surprised that GWL was aware of the initial CPP-D denial (notified by CPP-D) — she thought that that was just personal information between her and CPP-D. She believes she would have cared more if she was going to receive more income, if something was in it for her, and because there was nothing in it for her she didn’t take applying for CPP-D seriously initially. She felt like she was doing the work to benefit GWL, not herself. She is also aware that the indexed portion of the CPP-D benefit is not used to calculate the offset of her BCTF benefit. The details she refers to were about her hospital admissions and the fact that her doctor said she may never work again. She provided all her diagnoses and information about her ablations, and cardiac conditions. She also elaborated more on the form about what her life has been or was like at the time.

## **LTD/BCNU Participant Narrative**

T. is an early middle-aged woman, a former nurse, living in a large, comfortable, well-appointed home in affluent suburb of a large urban centre with her husband and dog. Incidentally, both her mother and adult daughter are also nurses. The interview was conducted at the dining room table of T.’s home. About mid-interview her husband, who had been elsewhere in the home, was going out and came to say goodbye to T. T. kept all of the paperwork from her disability benefit claim, including notes she made herself, and referred to these throughout the interview for accuracy.

T. has a long history of back injuries and had had a number of WorkSafe BC claims (ranging from a few months to a couple of years) prior to the injury that prompted her to apply for LTD benefits. We began by discussion the most recent claim, the third with WorkSafe. She started to return to work in 2006 at a central intake position in the health authority. Previously she had been a home care nurse, so the intake position was considered an accommodation enabling T. to return to work after rehab following a work-related back injury. But sitting for 8 hours a day was not a good fit, so T. decided to leave this position for a community care case management position. She tells me: “So that was why I kind of chose that — I was giving up my accommodation to make a better choice for myself I thought would be a more … I could get up and move and not tied to my desk for 8 hours.”

WorkSafe BC was otherwise “fairly accommodating” according to T., paying for an ergonomic assessment, a workplace sit/stand station, headsets, a rest room to lay down in, and topping up her salary whenever she was unable to work during a Gradual Return to Work, which took the better part of 6 months. WorkSafe BC also paid for expensive regular injections by her naturopath to reduce back pain. T. tells me that the employer is a “big believer” in work conditioning programs and was sent to one after her back injury. These programs are paid for by WorkSafe BC and operated by a local, private rehab businesses designed to condition a person to return to the work environment. T. agrees when I suggest these programs sound “regimented,” including 6 to 8 hours daily five days weekly at a gym doing exercises according to a back (or whatever) injury protocol, and attending educational sessions. Typically, back-injured employees work with physios, OTs and kinesiologists. T. tells me the program was physically challenging for her, resulting in painful flare-ups, and she felt pushed to complete the program (and get back to work). T. suggests that these “boot camp” programs are driven by economics, that is, success is measured by “graduating people back to work.” She says she “never graduated” from one of these programs, rather she was “removed” by her doctors and independent physio, because it was not helping her.

In this case, she is referring to the current back injury (her 4th, sustained in early December 2009 at the gym). She refused to return to a work conditioning program and ended up developing a rehab program more suited to her abilities, including attending the local rec centre and pool program and hiring her own physio, all paid for by Health Benefit Trust (HBT). This injury resulted in symptoms the next day that felt like those T. has experienced with a herniated disc, lower back S1-S2, for which she assumed she would need a few days off work. She went to her doctor to have a Proof of Illness form filled out, which she gave to her employer, the regional health authority. T. did return to work for about 4 days — mostly on a modified work — in early and late December, recognizing the form was a means for her to have her injury documented. In early January (2010) she received paperwork from the HBT Early Intervention Program (EIP), stating she had been referred to the program “because you've been off work due to an illness or injury.” T. tells me that by the end of December she knew being at work (her case manager position) wasn’t working: “By Dec 31 I was done. This wasn't working. I'm fakin' it but I'm not makin' it.”

When I ask what was entailed in the EIP, which she had not seen before, she says:

Well they sent me this lovely package (shows glossy package folder) but they give you papers and forms and it tells you to … here's a little bit more about long term disability. But it's a package that shows you the information you're going to process while you're going to be off, and who's going to be contacting you, and a program overview of how it works.

When I ask if she also is assigned a case manager, or vocational rehab consulate she responds:

Yes. An Ability Management Consultant, which was an employer representative. (names health authority) had one of those. I had my Human Resource person (names person) who was my Ability Management Assistant (both from health authority/employer).

T. does not recall if she had contact with the BCNU at the time, and doubts she did because in her experience she had to seek out the union rep to help her. She recalls being assigned a man from HBT (T. didn’t name his position) who told her “This is the route you're going to go. We're going to intervene. We're going to help you fast track and get you into programs.” Basically she is told she is going to be “supported” (uses non-verbal scare quotes) through the EIP. When I ask her what “supported” means she says:

Well it um … it's a lot of paperwork that you need to fill out.

R: What kind of paperwork?

I think it's just trying to understand your injury. It's kind of a bit repetitive. And I find that in the beginning it was all "Welcome. We're here to help you. Things are going to be … this is our process and the process is you know, "We're going to help you work through the stages of your injury, get you back to work as soon as we can. We will help you fast track different accesses to certain things if you may need it … make sure I have access to whatever support you may need to get through, with the goal of getting you back to work as soon as possible. In a timely fashion.

In this case HBT fast tracked and paid for an MRI, in April, but T. says did not actually sit down with anyone from HBT to discuss what her needs might be. She quickly used up what little sick and vacation days she had banked, so by February had been on unpaid sick leave for a while, which triggered a letter from her employer informing her she was now responsible for paying her monthly benefit premiums (medical, extended health and dental, and long-term disability — the latter at the cost of $334.26 monthly).

Interestingly she tells me she applied for provincial medical leave, but when I seek clarification she tells me it was EI medical leave, which covered some of the LTD waiting period (6 months at the time) but not the entire period. She did not receive an income from any source for a month or two, not insignificantly because the benefit premiums she was paying personally were at least $500 monthly.

In the beginning T.’s recovery progress was slow and not much was happening between her and HBT, although she was supported with physio and massage and “seeing whoever I needed to see.” In March, she was referred to a medical rehab specialist, a private physiatrist, paid for by HBT. Over the winter she also received phone calls from what she calls her “case manager” checking in “To see if I'm feeling any better, if I'm making any progress … do I still have pain?” According to T., her doctor and physio also provided updates (presumably to HBT). Her general sense of the process was positive in that, “they did seem generally eager to move me along in the right direction.” By early March, her progress stalled and her symptoms (pain) did not improve substantially. The EIP worker suggested at this time that she might want to think about applying for LTD benefits, which she did, completing the paperwork and sending it near the end of April. She describes the application process:

Oh, it's tedious. It's a lot of work. I think the biggest challenge is having … to validate everything you're feeling. Or trying to get that validated, and articulated to the appropriate professionals. And having them get the paper work done — doctors hate paperwork. They don't want to do that. And that's the biggest challenge I find even today is having them fill out paperwork.

R: And making sure they do it right.

Right. And so that a) we're not bombarded by more paperwork because "Oh we need more information here. We need more information there." And just the unknown of what's going to … what are they going to say, [sure] because they don't necessarily—I always find it fascinating when I read a consult and I think, "Do they have me? Like, is this the right patient?" Because sometimes it's just so … not what I said. Like, "How did you make this stuff up?" t's just very … it's frustrating.

T. agrees with me that “coaching physicians” is a challenging aspect of completing the application paperwork. She attributes her success to having multiple experiences with applying for programs and benefits, knowing how these processes work, being able to advocate effectively on her own behalf, and knowing how to “jump through the hoops.” For example, as a nurse and as a person who has had previous injuries she knows that most programs want to know how her injury affects her Activities of Daily Living (ADL), which she can describe clearly. Her primary source of frustration arises from the fact that neither her GP nor her specialists really know anything about what her daily life is like. She tells me:

It's a huge anxiety. It's a huge burden because you have to … that piece of paper determines your ability to have income you see.

R: Yeah, your livelihood.

Your livelihood. If they don't say the right thing then I have to go back to work, and I have to go through … not have to go back to work but the barrier of going back to work and having the demoralization of not being able to succeed at that again.

T. also expresses concern about being a burden to other nurses in the workplace, another demoralizing aspect of returning to work. In early May, her LTD claim is accepted “to June 10,” which actually meant she would be reviewed in June to determine continued eligibility. She described this period as “a lot of grey clouds sitting over your head … are they going to keep paying me?” In June, she receives a letter informing her she continues to qualify for LTD benefits beyond June 10, under the “own occupation” definition of disability. No explanation is provided for this month-long period, and in mid-June she is informed that the EIP is terminated.

The June letter from HBT informs her that as part of her LTD “contract” T. would be required to continue to consult with specialists and comply with medically-recommended treatment, to which she agreed. In addition, this first “phase” would be reviewed mid-September and in phase two — if she’s medically able (reading from HBT letter) — “you're required to participate in a rehab plan to facilitate your return to work jointly determined by you, HBT and if you choose, your union. If you don't agree with the plan or are medically unable to participate your responsibility is to demonstrate reasonable grounds why you’re unable to do so. If this is the case your union may be able to help you with an appeal process.”

During the summer, Great West Life (GWL) requested that T. complete a “CPP-D status form.” She tells me

I didn't have a lot of enthusiasm to fill that out because I had no intention that this was going to be a long-term disability that I needed CPP for. But they make you do it.

R: Yes. That's a requirement.

Just to torture you. Just to torture everybody, and again filling out the paperwork, the cost of doing that. The request of the GPs and the stress of doing all that. And not knowing what's going to happen. But knowing it's not really relevant.

T. postpones the CPP-D application, and sometime in the fall was referred to a back surgeon who did a minimally invasive micro-discectomy (L5-S1) in day surgery. T. describes the results: “I woke up and I was ready to hike a mountain — I was a new person, instantly. It was fantastic.” Unfortunately, she experienced serious withdrawal symptoms from the Fentanyl patch used for post-op analgesia, including nausea and vomiting. She had been mistakenly told to leave the patch on for five days, which she knew was incorrect. When she called the nurse hotline and pharmacy on the 4th day post-op, she was told that all the narcotic would have left the patch by then. As a result, she ended up being on Fentanyl (patch) for almost a month titrating off the medication.

In December (2010), T. saw her GP to have forms from GWL and HBT completed. She was scheduled to see her neurosurgeon in January; they requested he complete a medical questionnaire and provide a narrative report focused on symptoms, clinical findings, impact of pain on activities, personal care, home management, recreation, shopping and driving, functional limitations, tolerance for walking, standing, sitting. They also asked him to assess whether she had improved to the point where she could return to work part-time. T. says she got her GP to complete this request because her experience told her that the neurosurgeon “has no insight.” Her GP responded, informing GWL that T. was not ready to work because she was de-conditioned, weak and had residual pain. He stated that she would like return to work in about 6 weeks, as otherwise she was doing well post op. Nonetheless the neurosurgeon did send a letter to GWL after her January (2011) follow up appointment, stating that she "Has discogenic disease, understands this is a long-term issue.” T. continued to engage in post-surgery rehab during this period and was improving. In February she received a letter from GWL informing her:

"The medical information indicates you're medically able to participate in a in a rehab program or activities that will facilitate a gradual return to work to your own occupation as a part-time long-term care case manager in March 2011. You will require approximately 2 months to complete your gradual return to work."

She remembers feeling quite keen about this prospect, which also included a clause that her LTD claim would remain open until either she returned to work fully, or May 31, 2011. However, shortly after she received this notice and before she could actually begin her return to work, T. fell on a slippery deck, landing on her coccyx. For the rest of 2011, she refocused on pain management: seeing her naturopath for 6-8 weeks of anti-inflammatory injections, massage, pool therapy, nerve blocks through an anesthesiologist in private practice. All her extraordinary medical expenses were paid for by HBT (the course of injections cost over $1000). They also paid for trips to Vancouver, mostly to have tests that could be fast tracked, like bone density tests. She was also having some unusual side effects from a medication she was on for nerve pain, like shortness of breath and some gastric symptoms. At the end of December, T. saw her GP who discontinued the medication, with positive effect, and referred her for a sigmoidoscopy because of a long history of “gut problems.”

Following the test in January 2012, T. was diagnosed with adenocarcinoma (rectal cancer) and abandoned any plans to return to work because she anticipated having surgery. In February she received a letter from GWL informing her they are (direct quote from letter):

beginning an extensive review of your claim to determine whether or not benefits will be payable beyond May 11, 2012, which is the end of your 2 yr 'own occupation' period. This review will assess your ability, education, training, and experience to perform one or more gainful occupations, which are currently in the marketplace and are expected to be in the marketplace for the foreseeable future. First, consideration for occupations will be within your health service delivery area and then within the area of your health authority. Thereafter occupations outside these areas but within BC will be considered.

T. is referred to an oncologist at the cancer clinic, who referred her to a colorectal surgeon in Vancouver to review treatment options. She didn’t actually have her first surgery — removal of tumour and creation of ileostomy — until April 2012 and a subsequent surgery in July to reverse the ileostomy. Before these events, at the end of March she receives a letter from GWL reminding her that her 2yr ‘own occupation’ claim ends May 11, 2012, and after that her claim (reading from letter) “is assessed under the 'any occupation' definition of disability. This means your illness or injury must prevent you from working at any occupation (unintelligible) at least 70% of the current rate.”

Unfortunately, postoperatively (both surgeries) T. had very serious complications, in particular after the reversal surgery which further disabled her. She tells me

So the first six months you're kind of — your body's adapting, you’re trying to figure out what's going on, understanding what the new normal is going to be. I had major surgery and special diet restrictions and things like that. I'm working very closely with my naturopath. My GP has no idea what to do with me.

Eventually, after 2 years of not really getting effective treatment from her regular gastroenterologist, T. requested a referral to see the original surgeon, who had moved to Vancouver just after her July surgery. He recognized that these effects should have been recognized much earlier, like during her recovery, and prescribed a rigorous treatment lasting almost 18 months, that resulted in further serious complications. She remained on LTD during this period and remembers still getting phone calls from GWL and health update forms to complete about every 8 weeks. Her experience of this was

stressful. And costly. And again it's that whole process of feeling like you have to jump through the hoops to … and you're tired and exhausted and you can hardly cope, and you don't know what the hell to do with yourself.

T. also remarks (humourously) that the workers at GWL, especially males, were uncomfortable hearing details about her dysfunctional bowels. However, she saw health care professionals whose services were either minimally subsidized, or she paid for them herself. She estimates she spent between $4000-$5000 on naturopathy alone, which was essential to her functioning.

In mid-2016, GWL decides she only has to report yearly: “Again it's just been the same thing—go to the doctor, fill out the form, and verify your disability.” When she was first diagnosed with cancer in 2012 GWL “made her” apply for CPP-D, which was denied, but in 2016 they requested she do so again, which she did successfully.

T. reflects on the pain and grief she has experienced realizing she can no longer practice as a nurse, which she finds hard to process. She asks “What am I? And who do I call myself?” Interestingly, she still holds out hope which gets enlivened when she tries new treatments and her GI health seems to improve for a few days. T. remarks that completing the forms for GWL and having to go to her GP and living with the uncertainty whether he’s going to complete the form (he’s near retirement) is stressful. Her naturopath is more engaged and provides more information than her GP does; it bothers T. greatly when her GP (referring to the naturopath) asks:

"Well can't he just fill it out? Like why do I need to? I see you once or twice a year because I can't do anything for you." But it's the frustration of the process of all that as well and again the expectation of the GP as the be-all end-all or the specialist, who don't really necessarily know what is happening with the day-to-day ADLs, or whatever, what life's like.

Our interview was in the first week of May and T. has not yet heard from GWL about her yearly review in March, which "just sits there and nags along with everything else, nagging at you … And being all … you know having to get all the documentation, you know, it just keeps scratching the scab off the wound. They can sure … you just sit there and think about yes, I can't do this, this, this, and this because … it's just always in your face.” Here she refers to the fact that she has received a letter that tells her she is covered until 2019 when she will be reviewed again.

T. receives a benefit equal to 70% of the first $5843 of her pre-disability monthly earnings, and 50% of the pre-disability monthly earnings above $5843 or 66 and 2/3% of the pre-disability monthly earnings, whichever is greater, as per the collective agreement. Her position was a .9 part-time position. I didn’t ask what her LTD benefit income was. Every four years she receives a weighted increase tied to wage increases over that period. Interestingly, the $5843 “base” level is to be increased annually with the increase in the weighted average wage rate for employees, for the purpose determining the benefit amount for eligible employees at the date of disability (from the BCNU Provincial Collective agreement).

She describes being on LTD benefits this way:

I think that's the biggest challenge of being on disability is the … besides the paperwork and not being who you want to be but … (unintelligible) I won't go into that. I'm fine.

R: Well I think what you're trying to say is that you're also having to deal with physical symptoms not just of one type [yeah] but two types, one's probably exacerbating the other.

Absolutely, yup.

T. also expresses concern for those who don’t have a financially secure partner to carry them through, and the impact of the expense of living with disability with a much lower income on their financial situation.

 That is that cloud that always … even though money is still money … it impacts whatever we do and how we do it, and having that constant strain of that financial component is big. And I feel very blessed that I don't live in poverty because I don't … yeah … how can anybody manage in this predicament if you don't have the finances to kind of … you know … it's a real … it kind of feels like it's a double whammy. The doors are closed. You don't have the opportunity to open the doors that you need to and I'm blessed enough to have the opportunity to do that. Because if I didn't I wouldn't be functioning as I am either. That's my reality.

## **AISH Participant Narrative**

Our interview was conducted via Skype. K. is a middle-aged woman who in 2008 left her abusive husband after 15 years of marriage and no longer had a spouse to rely on for income. Having been previously institutionalized for mental health issues, she applied for AISH after leaving her marriage. Her mental health issues were more marked during her marriage, and less so once she separated. She has three children, born in 1997, 1999, and 2001. Her middle child, a son, was diagnosed on the autism spectrum in 2003. She tells me: “…at the same time I developed extreme insomnia so I wasn't sleeping which made me eventually mentally unstable as it happens.” She was admitted to hospital to treat the insomnia but was diagnosed with depression, for which she was prescribed antidepressants, resulting in rapid, large weight gain and as she says, “I got turned into a bit of a zombie for awhile.” In 2004 her eldest child, a daughter was also diagnosed on the spectrum. Her husband didn’t believe in invisible disabilities and was unsupportive regarding the children’s diagnoses. K. attributes her eleven psych hospitalizations (9 acute and 2 into a residential care facility) to the spousal abuse she experienced. Her admissions happened in different ways — through Emergency, from her family doctor, self-referral, and being ‘certified.’ Many of the hospitalizations were because she was suicidal, and she has had none since leaving her husband in 2008, nor does she report being suicidal since then.

Currently she lives with PTSD arising from abuse and was diagnosed with autism, which went undiagnosed during her hospitalizations. According to her, “the mental health issues are way more disabling than autism” in particular immobilizing anxiety, exacerbated when she has to engage in bureaucratic processes, for example, or seeing her husband during legal processes regarding child support.

At the time she applied to the Ministry, K. was housed for 43 days at a women’s shelter, whose workers helped her apply for “not expected to work.” (This might actually have been the “Expected to work/Barriers to Full Employment social assistance category—there is no “Not Expected to Work” category). Alberta Children’s Services returned K.’s children to her husband for six months “because I had mental health issues and autism and they didn't think I could care for them.” Her husband said that K. "was dangerous and unstable,” so for a very short period of time she had supervised visits with her children.

K. had used most of the cash she had saved as part of her “escape plan" from her husband to pay lawyers. As a result, she qualified readily for social assistance benefits, given the financial criteria as she understood it (“less than $1000” in savings). She retained lawyers to change the court-ordered terms for seeing her children:

the way the court order was written was that I couldn't see my kids unless I returned to the marital home. And I'm like, "But I'm not going back. It has to be different.” And so it cost money to have a lawyer to rewrite it so I could see my kids without having to go back to the marital home.

As a result of spending most of her savings, K. had no cell phone or way to contact the Ministry/AISH so ended up in their office:

Just sit and wait for the next available person and then they would tell you what information that you needed to have. So you would go and gather it. I had a bicycle fortunately, no vehicle. So I would get whatever the next information thingy was and then go and sit in the office — because they don't take appointments — until the next available worker. And repeat that until the process was done. And every worker kind of assumes you're there to try and take the system for granted. So it's like —g oing in is like being treated like you're trying to steal.

K. tells me “I had letters of support from the women's shelter to expedite the process.” But “Income support in Alberta isn't enough to live on. I couldn't move out of the shelter until I had income support and rent subsidy.” The executive director allowed K. to extend her stay at the shelter (21 days is the limit) another two times (21 days +1) because of extenuating circumstances. Social assistance provides only income support, not rent subsidy, and until a person has secured social assistance plus the rent subsidy s/he cannot sign a rental agreement. K. tells me that rent subsidy

is a separate program. So Alberta doesn't provide enough income support for housing, and so then you have to apply to the (names city) community housing association and go through their entire intake program, which is different criteria for qualifying than income support. So I was interviewed there.

She tells me that she understands that Alberta Family & Community Services sends money to municipalities to subsidize services as deemed necessary by municipalities. Included in this is an annual grant to the women’s shelter society and the local community housing society to help meet operating budgets. She also visits the food bank because she doesn’t receive enough from AISH to eat. K. tells me that all three are necessary to survive: “The food bank, community housing, and income support in order to … like you need all three in order to make ends meet.” In order to qualify for food bank services she had to go through another bureaucratic process: “Yeah, there's an intake process which is different than the community housing and the income support process in order to qualify for their services.” She reflects on the fact that it was a blessing she didn’t have her children during that period “And I didn't have to take them along with me and find babysitting and … not that that was preferred, but there's a silver lining that can be found.”

Once her applications for social assistance and rent subsidy were approved, K. moved with her children from the shelter to second-stage housing at the women’s shelter. Alberta Children’s Services assisted K. with qualifying for second-stage housing, a 6-month program to help women and children “regroup” after leaving the shelter. However, K. was required to resign from the community housing association rent subsidy program to enter subsidized second stage housing, which meant she had to reapply for the rent subsidy once she left to find her own housing.

Luckily, her mother bought a house that K. could rent. Interestingly, the mortgage had been paid off on the home she still co-owned with her ex-husband.

She had applied for AISH at the same time as she had applied for social assistance, and later had to appeal. K. recounts the process:

Yeah, I had an amazing intake worker because you can't qualify for AISH if your assets are over a certain amount. And according to the black and white rules my house [co-owned with ex-husband] was considered a secondary property because I wasn't living in it. And I'm like "But I can't live in it. There's a court order and I can't live in it. It's not a secondary property, it's my primary residence that I can't live in." And she was willing to stick her neck out and say, "You're right. That's not OK." And I was able to qualify financially even though I wasn't living in my house or should've counted it as a (secondary property) … so that was awesome.

K. also sought the support of her physicians to complete medical reports on her behalf, including her regular psychiatrist, who was acceptable for the “not-expected-to-work” application but not for AISH, which requires one or more specialists to complete the medical assessment. In K’s case this means her psychiatric specialist, who practices in larger urban centre.

The appeal arose when a Ministry worker decided “this isn't what the policy is meant for,” meaning K. qualified financially for AISH but had to appeal on the disability criteria. She says

I also applied for PDD — Persons with Developmental Disabilities — where you can get help for adaptive supports. And I don't qualify because you have to have an IQ of 70 or lower. I obviously don't have that. But it was very hard for the appeal board that I couldn't keep employment. That … like I should have to try again now that I was single, to go to find work.

K. had a friend from church who worked for the MS society who had attended many appeals; she went to the appeal hearing with K. for moral support. She also had a community health worker attend the hearing with her. K. recounts:

I was massively stressed, because if I didn't get this I was going to be having to find work and I knew that would send me back to hospital for mental health issues. And then the appeal board on the day of the appeal — at the time I was supposed to be going in for the appeal they said, "There's too much paperwork here to read. We're going to have to reschedule." So I unintentionally had an autistic meltdown. 'Cause there was a lot of … like change [to deal with]—yeah. Like I had been told like this day and then you'll know. And then it actually wasn't that day. So my worker got rather mad at me because '(names self ) this is important.’ And I'm going … yeah I've got my head between my knees and almost crying and then they're like 'I guess we can do the appeal now.' So they did end up doing it.

The appeal panel pretty much covered me with every kind of employment I've ever had and why each employment ended. Because they thought I hadn't demonstrated that I was unemployable. So like it's not based on if you have a disability. It's based on if you can be employed or not.

The panel asked K. about previous employment as a way of trying to discern whether she currently employable. She explains:

Because I had had some periods of successful employment, like in my early 20s before abuse, and before psychiatric stuff, and before the stress of parenting special needs kids, and before getting wrongly medicated for being … for not being able to sleep, which … they wanted me to try employment again. I didn't have enough … I hadn't failed enough yet.

K. believes the focus on previous employment was primary for the panel. Her previous experience of vocational training in psych rehabilitation worked in her favour. It included very simple, monotonous tasks which she couldn’t sustain due to her mental health, and she was “kicked out” of the institution. On a subsequent admission she worked in the publications department and designed the website for the health region. But her mental disability made it hard for her to sustain this work and relationships with co-workers. Again, she was asked to leave, which she believes contributed to her successful appeal, for which she waited another four weeks.

During this time, about the middle of January, K. got into second stage housing with her children, but until the appeal was settled, she had no idea of she would be financially able to sustain this. Eventually, she received a phone call to go in and meet her AISH worker. This worker was the one who was willing to flex the rules given K.’s court-ordered family arrangement, but along with the advocacy she provided the worker also encouraged K. to “Ask for it. We can always say ‘no.’ But if you’re not sure — ask.” Her current worker is less forgiving — K. thinks the worker’s job “is to try and see how many people in the system she can disqualify. Like she's just on me extremely often.”

I ask what the first worker actually told K. she was going to get and what was available to her as part of the benefit.

Because there's two levels of AISH — if you have under $3000 then you qualify for extra stuff.

R: Like?

Like $100 a month for each of your children and financial help — like they paid for my bus ticket to go into Calgary to see my specialist. And um they helped with my son — he needed orthotics. Um … I needed a night guard for my teeth, so they paid for those things. When my assets went over $3000 then they didn't provide any of that anymore.

K.’s assets exceeded $3000 after her divorce was settled in December 2013, five and a half years after leaving her husband. She was able to remain on the AISH program but was “kicked off” earlier this year. She tells me she is “back on and in an appeal.” I asked K. if she had to report the settlement income to AISH:

Yeah and I had to convert the lump sum settlement into exempt assets within thirty days.

R: And what are "exempt assets"?

AISH's exempt assets are: primary residence, primary vehicle, prepaid funeral, a LIRA.

R: What's a LIRA?

I might have the acronym wrong — "locked in retirement account." [see:<https://en.wikipedia.org/wiki/Locked-In_Retirement_Account>] It's where you can convert pension but an RRSP is not exempt, but a LIRA is even though they're both retirement savings.

R: They're telling you that the settlement you got in your divorce has to be treated in a particular way to enable you to continue to receive AISH.

Within a specified amount of time.

K. went to her investment advisor who informed her she was not eligible for LIRA, but because under AISH regulations a primary residence is exempt, she used the divorce settlement money as a down payment on the purchase of the house she had been renting from her mother. AISH doesn’t accept electronic copies of documents so K. “…had to bring in the bank statement that showed I received the divorce settlement and the house papers to show that I had purchased an exempt asset.” Interestingly, delivering hard copies requires her to attend the same provincial building where children’s services is located, and she experiences a kind of PTSD every time she goes to the AISH offices. She describes it this way:

I don't communicate as clearly, things become a lot more black-and-white. And then I need a whole lot of time — my legs shake like jello and I can't make decisions for a long time.

K. recounts her difficulties with the current AISH worker, with whom she is in contact:

Even though I've given written instruction that I want communication only in writing, not over the phone, she still phones. And when I go in to drop things off — ‘cause that's the only way I can give them documentation — she like asks me questions at the counter.

Currently, a friend serving as an advocate takes documents into the AISH office on K.’s behalf. We return to a discussion of the situation she was in when she was disqualified from AISH.

In July of 2016, my at-the-time 14 yr old just walked out of the house without warning and went to live with her Dad. So I let my AISH worker know that I was receiving Child Tax Benefit for her and I was receiving child support for her, and we were now back in court and I was going to need to pay back the money I was receiving because the system was going to take a while to catch up. And was there anything more she needed to know from me? Because you have to report any change in family, any change in income, any change or they can take it away from you.

Her daughter decided to stay with her Dad, rather than return to K. at the end of the summer as she expected. At that point, her husband served her with change of custody papers. K. let her AISH worker know about this development at the beginning of September. She continued to receive and report child support payments for her sons, which AISH deems exempt income. The court case was adjourned twice, and scheduled for March 2017. By this time, she was nearing her annual review in May in which she has to submit financial documents to ensure she still qualified financially for AISH. Her situation had been complicated over time because of the 5.5 years of divorce proceedings, during which time her assets were frozen, and K. required a legal document (a lawyer’s letter) every 6 mos. detailing the situation and her inability to access her assets. The asset limit now is $100,000 and K. had several non-exempt sources of income, including a very small business, RRSPs and life insurance cash surrender value. At the time she spoke to the AISH worker in September 2016 she says

part of the divorce settlement was I got to keep my spousal RRSPs, so it put me extremely close to the $100,000 limit. So I couldn't keep any cash on hand pretty much. So that's why I let my AISH worker know like, "I'm getting money from my daughter that I'm going to have to pay back when the court is settled." And it was OK.

It was alright for her to receive the money for the time being because she knew she would have to pay it back, and communicated this to the AISH worker, who thanked her for informing AISH about the situation. In early January 2017, K. received a call from her AISH worker informing her that her file was being reviewed (five months before her scheduled annual review). The worker

accused me of stuff that I was in a bit too much shock to remember the actual words, but I found out later she accused me of having a $25,000 account that I had never disclosed before, which didn't exist. And they've never … just … anyway that I as of that phone call I no longer qualified for AISH. And I got a follow up letter saying "You have thirty days to provide your income." So I'm like "OK she was just having one of her bad days." And I just need to provide the paperwork. But before the thirty days were up my AISH file was closed … So I learned that an AISH file can be closed over the phone, and they don't even have to send you writing that says your file has been closed.

K. appealed this decision and lost “because you never win on the first appeal with AISH.” She had to determine the cash surrender value of her life insurance as part of the appeal process, which her insurance agent believed contributed to her assets being over the exemption limit. But K. is shocked that when she communicates everything above board and AISH says it is all acceptable to them, they reverse their decision. She says:

…within thirty days of court being over and the settlement being cashed I'm back under my asset limit. Like I followed their rules but they can make stuff up on the phone and my daughter has researched the AISH act and regulations and yeah there is no policy in place that they have to inform you in writing and the director has ultimate say in everything. So every regulation can be overruled by a human being who chooses to.

In July 2017, K.’s insurance agent appealed on her behalf on the basis that her life insurance shouldn’t be counted against her. She had to provide monthly financial statements dating back a year (June 2016) so AISH could accurately determine when she exceeded the allowable assets. To complicate matters, her custody court case was in March 2017, after which she paid the money back she had received during the time her daughter was living with her husband, and qualified again for AISH. She received AISH benefits for April and May 2017, having lost her February and March benefits. But this was not the end of complications, according to K.

… at the beginning of March 2018, I received an assessment of overpayment, which says I need to pay them back $11,000 because from when my daughter left until they cut me off AISH in January I shouldn't have received AISH for those seven months. Even though I let my AISH worker know and she said it was OK that I went over. And so I owe them all those months back.

K. says that AISH calculated a $900+ monthly overpayment during the period August 2016 to January 2017, apparently because she was receiving child support in excess of what was allowable, and also receiving the child tax benefit as if she had two children instead of one. She says this income resulted in her exceeding allowable assets, mostly because she had a large spousal RRSP. But in September 2016 she had discussed this with the AISH worker and had been told it was acceptable, because she actually couldn’t access the RRSP. K. tells me

If I had been told it wasn't OK I would have just upped my house payments 'cause that's exempt. I would … like … I'm not stupid. If I had been told "No you've got to make sure that you don't go over that magic number, I would have found a way not to go over the magic number.

K. was given thirty days to appeal the assessment of overpayment. She filed her appeal papers in late March 2018. At the time of our research interview no tribunal date had been set. To complicate matters, she returned to the insurance agent who previously helped her pro bono, to ask him if he could help her again. He said he would have to charge her, and then gave her a bill for all the previous help, which at the time of our interview she has not paid. Subsequently she has a friend who is advocating for her, a former bureaucrat from Saskatchewan, and a lawyer-mediator, who had also previously signed the letters to AISH saying her assets were frozen. K.’s approach to the appeal has been twofold: 1) she is financially unable to repay the amount, and 2) counter the worker’s insistence that she did not tell K. that going over the allowable limit temporarily was acceptable, by pointing out that if it hadn’t been acceptable that K. would have made different financial decisions.

I would have done it differently. I wouldn't have on purpose gone over for seven months. When I told her up front that this was happening. Like it makes no sense, but AISH doesn't have to make sense — it does whatever it wants.

K. has requested an accommodation that because of her autism and mental health condition, including PTSD, that all communication be in writing so she has time to process it. She sees this as a basic human right, which is being thwarted by AISH: “That is a basic human right to have … and there my own disability service provider is not accommodating my disability.” She tells me she is terrified of her worker. I ask why and K. says

Because she says one thing and does another and gets mad at me on the phone and cancels my benefits and then sends me a letter and says something different on the phone. And she has the financial bullet that triggers all of the financial abuse that I had to leave in my marriage. And she has all the power and control and I have to hop through her hoops, but the hoops change and I can try as hard as I can to be as proactive as I can to find out what the rules are and try and follow them. And it's just like being back in the psychiatric ward that I got kicked out of back in (names psych rehab centre) that didn't work out. She trips me up.

K. has been told by this worker that if she is required to pay AISH back they will claw back 10% of her benefit until the debt has been cleared. She tells me she can’t live on $1400 monthly, especially given she is paying child support out of her AISH benefit of $1588 monthly to her ex-husband for her daughter.

K. tells me she is not willing right now to ask for another worker, because she understands that the director can waive overpayment and she doesn’t want to jeopardize that possible outcome of the appeal. She will ask for another worker once the appeal is completed, and though she has no idea if others are better, she trusts that she can work with the system given positive relationships with three previous workers. She tells me she will be going to the provincial Ombudsman should the appeal not be successful. K. is also aware of the Alberta Auditor-General’s report on AISH and findings that it is not consistent across the province in how applications are treated. (See pp. 23-24 this report for a summary). Apparently, the only change in the works as result of the AG’s report is putting more money into helping people apply. K. is sceptical when I suggest that that is a good recommendation: “…except if you can apply and still not get it, or be kicked off shortly thereafter, they're not tracking enough stuff.”

November 14, 2018

Email to K.:

Mostly I just want to follow up with where we left off. At the time of our interview you mentioned that your AISH claim was in appeal regarding AISH’s assessment of overpayment, and that no Tribunal date had been set yet. I know you were hoping the AISH Director might opt to waive the overpayment.

My questions are:

1. When did your appeal go to Tribunal? What was the outcome?

2. If the Tribunal decided against you, did you follow through on your intention to seek assistance from the Alberta Ombudsman? If you did, where are you now in that process?

November 15, 2018

Email reply from K.:

AISH is stalled.

I received a letter dated May 7 that my request to waive the overpayment was denied and it is not appealable. I owe just over $11,100.00. However, I received a letter in June with specific questions to provide more information by July 9 which I did. I have not had a response from that submission.

In May, I also filled out the form to appeal the assessment of overpayment. I don’t know what is next in that process or even whose turn it is to file something. I can’t go to the Ombudsman until all avenues of appeal have been exhausted.

I completed the FOIP process the end of May to get a copy of my AISH file — 891 pages! It arrived at the end of July — by law FOIP is supposed to take 30 days. I have only read some of my file as it makes me feel ill. There are a significant amount of errors and omissions in the parts I have read.

I continue to receive the full monthly AISH benefit of $1588.

## **Alberta MVA Participant Narrative**

The research interview was conducted via phone. MH was 23 yrs old in 1994 when he rolled the truck he was driving while impaired. He got thrown out the windshield and sustained a spinal cord injury, broke all the bones in his face and became blind. He is paraplegic.

He was in intensive care for 3.5 weeks, and acute care for 6 months, then rehab for almost 2 years. He remembers very little of the early days, just that all of the applications for benefits were completed and submitted by his parents.

After the accident his parents applied for CPP-D and AISH right away. He recalls that because he had worked, he was on CPP-D “for a while,” receiving about $650 monthly from CPP-D and about $850 from AISH. Also, because he had two small children, one and three years old, he received CPP-D benefits for them. M. does not recall if his AISH benefit was clawed back by the CPP-D amount and remembers receiving between $1200-$1400 monthly, including the CPP-D benefit for the kids. He agrees with my hunch that this monthly amount suggests there was a claw back.

M. also opened an auto insurance claim because the front end of the truck “broke” during the accident. He hired a lawyer on retainer to help him with a legal claim against the people who sold him the truck, arguing that this truck malfunction was the cause of his injuries. The case lasted about 2 to 2.5 years, including taking the truck apart and having engineers test it, but was ultimately unsuccessful. M. paid the lawyer about $500 for phone calls and paperwork. His brother handled the claim with the lawyer on M.’s behalf.

M. also received the Alberta Motor Vehicle Accident Claim fund, which his family learned about through the Canadian Paraplegic Association (as it was called then) and applied for on M.’s behalf. It included a one-time $100,000 grant given to people who had been in an MVA resulting in permanent disability. It is to be used for equipment, for example, wheelchairs (over time) and ramps, or making his home accessible. Currently, M. has about $5000 left in the grant.

M. is currently receiving CPP-D and AISH, having been off both benefits from 2000 to 2015, because he was employed during that period. He successfully challenged the entry exams into college, foregoing the need to upgrade his high school, which he did not complete. M. subsequently earned a social work diploma. He received both benefits while attending post-secondary education, and supplemented his income with a student loan. As an accommodation he received Alberta Special Opportunities Grants (disbursed by the college directly) to have a person accompany him to class for note taking. Interestingly, AISH’s policy delayed his diploma completion date as he recounts

And back then the way rules worked with AISH you could only go to school part-time. Because … the way they looked at it was if you could go to school full time you can work. But you need the education to get the job, right?

After completing his education, he was employed for three years at CNIB, and then as a disability advocate at his regional Independent Living Resource Centre (ILRC) for about 4.5 years. During this time, he was appointed to a disability advisory council to the Alberta premier, at which he remained at for 9 years, 3 of them as Chair of the council. He tells me he worked two days weekly for the council, received an honorarium and was reimbursed for expenses for his service on the council. At the same time, after working at the ILRC, he worked part time for 4 years as an employment counsellor for the Canadian Paraplegic Association. During this time of employment, M. did not receive AISH or CPP-D benefits. Also, since 2001 he began his own very part-time business printing Braille business cards, which he had been doing for the executive director of the ILRC. Currently, this self-employed income pays his utility bills.

M. returned to both AISH and CPP-D in 2015. When I ask why he says

Well I went through another divorce in 2015 and then I couldn't find work and I also — I guess basically I had some more health problems. I can't sit for hours and hours on end because I get pressure sores. So if I get up in the morning —get up at 5 o'clock in the morning, get ready, go out the door, ride our accessible transit service here, go to work for 8 hours, come home — you're putting 14, 15 hours in the saddle right? (laughs) [yeah] It's just too long. I can't do that. So yeah in 2012 when I lost my job at the CPA due to funding cuts I just kind of went full-time with my own business as I could.

M. tells me his wife left him and his kids after the accident, and he remarried in 2002. His second wife was employed so their combined income made M. ineligible for AISH. Also, M. made about $1000 monthly from his business, and when his marriage ended it was not enough to live on. Finding work was challenging because it needed to be more or less sedentary and M. is prone to decubitus ulcers if he is sitting for too long. So he re-applied for AISH which

was pretty easy for me because when I worked for the ILRC for 4.5 years that's most of what I did was AISH applications and AISH appeals, and I had a100% success rate.

Here M. refers to the dual role of being an advocate for AISH applicants and helping them complete the forms as a social worker. He became eligible for benefits once again within a three- month period, and gives me his take on how best to advocate for others applying for AISH:

Well basically what I found that worked Sally was … I think I'm a compassionate person, or at least I hope I am. What worked for me in the AISH system was essentially making the person look totally unemployable and for lack of better words, useless. And that they weren't capable of doing anything. And that worked. I certainly over stressed that it was just for this application process — so it worked. That's their game. And the game I guess is once you're on AISH — as you know — you can work. They encourage you to work. But to get on the AISH they want you unemployable.

He describes this as “a degrading process.” His family doctor was very supportive through the AISH application, as he points out when he says, “that's the gold ticket having that medical piece supported.” Monthly M. receives about $1588 from AISH and about $1000 from CPP-D, which is clawed back dollar for dollar from his AISH benefit, so $1588 monthly in total. He believes strongly this clawback is unnecessary and restrictive. With AISH he receives full medical coverage, including prescriptions (no co-pay) and basic dental work. Interestingly, AISH will provide $50 monthly to support M.’s service dog, as long as he doesn’t have in excess of $3000 in his bank account. He tells me this also applies to diabetics who have special nutrition needs. M. has to purchase his service dog out of his own pocket, typically a $100 administration fee, which is considered a CRA medical expense, as is anything to do with the dog, for example food and a fence in the back yard.

When drawing from the Alberta Motor Vehicle Accident Claim fund, M. has to submit two quotes for a new wheelchair for example. In his opinion, decisions are made on the “bottom line” not the person’s needs. In response, he tells me how he has to “play the game”

I'm 6’7" 255 lbs. So I have to get my chairs custom made. So I get a quote … from someone else first and my wheelchair guy — I just get the first quote and he just beats the first quote … by about $100 or something. So I get the equipment that I need. That's all you do.

The quotes are sent to the Motor Vehicle Accident Claim branch in Edmonton for approval. Once approved the wheelchair is paid for and ordered from the vendor. It takes about 4-6 weeks for the branch to approve it and the 3 to 4 months for delivery. The whole process is initiated by the disabled person and does not require a doctor’s approval or verification. Through this program M. has also purchased a computer screen reader — a talking device — so he can read and write. He also used part of the grant — about $45,000 — to renovate his house in 2004, which also required two quotes. Quotes are not needed for repairs to his wheelchair or to the air cushion he uses, just for new purchases, for example a new air cushion.

M. is on Self-Managed Care, which he describes this way

Here in Alberta through home care — through the Alberta Health Services we have — you can go on basically private care. So what happens is I'm assessed through home care for how much care I need and they give me the dollars and I'm my own manager, I hire my own staff.

M. has a separate bank account set up for this service, into which the health services deposit funds for care, calculated against the number of hours of care he is assessed to receive (approximately $3000 per month). A private company does his payroll for the home care worker, including her WCB, EI and CPP, for which he has to budget. M. hires one worker at a time that have stayed with him for different lengths of time. This past December (2017), M. hired a woman who comes in 4 days a week, 8 hours a day to help in the home with housekeeping. She also goes with him to appointments, especially important if they are in buildings he might get lost in due to his vision loss. She accompanies him grocery shopping, travelling on accessible transportation buses, assisting with reading mail. Mostly he needs help because of his vision loss, not because he uses a wheelchair, and figures is he wasn’t blind he wouldn’t need anyone to help. M. does all his own personal care. His home care person also sets him up for the remaining 3 days. When I ask him why he chose to go with Self-Managed care instead of receiving home support from the health region’s community care program, he tells me

 just have more control over who I can hire and what-not. If you have an agency, you know 4 days a week it could be a revolving door of people.

M.’s son, who works full time, lives in the basement and contributes to the household expenses, and helps with transportation. As long as his son applies his rent payment directly to M.’s mortgage, it doesn’t jeopardize M.’s financial eligibility for AISH. The advice AISH gave M. in this circumstance was “Just don't channel it through your bank account,” meaning make sure his son’s monthly rent payment isn’t deposited into his bank account. M.’s son buys most of the groceries and they eat together.

We discuss the difficulty getting information about services and supports and M. mentions the internet as a good resource, not one available to him when he was injured and seeking help. He tells me that helping people return to work means ensuring supports are in place

Like when I was doing employment [counselling] I looked at … you have a quadriplegic — what are their supports? How's their equipment? What's their support to get them in their wheelchair and get them out the door? You have to know that before you can even think of getting them a job.

M. seems proud of the work he has done assisting others to get the services they need. He even spoke about how he did a lot of “policy work” —

tearing policy apart to help people with their appeals. I remember back in the day the AISH appeals officer hated me! [laughs] Because I would go in there and just tear their policy inside out and backwards against them. Cause as we know there are lots of flaws in policy. If you know how to read it. It was fun!

M. has not given up on work and tells me about a job offer he is anticipating,

I've got a job offer pending for doing something totally different. I'd be working from home so I've got equipment set up and how my house is set up I can actually run my computer from laying down in my bed or whatever I need. A moving company wants me to actually come and work for them in their call centre. Hopefully they're looking at an HR position … they're putting together an offer as we speak. Again, the problem is that I have to make enough money that it's worth losing my benefits.

When I ask how much that might be he says

Not much. 'Cause I already have earnings coming in from my company, so I make about $600-$800 a month from my company, so I'm kind of maxed out already what I can make [allowable earnings]. So I've got to make that much more, 'cause I'll lose it all.

M. says he would have to earn at least $1500-$1600 monthly from employment in order to make it financially worth his while to let go of his benefits. He suspects he would likely work part-time instead of full-time and at the time of the interview was waiting for the employer to make him an offer. He is concerned that if it is part-time employment he may earn less than he receives with his AISH and CPP-D. Although he reports yearly to AISH (and CPP-D), if he returned to employment he would have to declare this change right away to the AISH program (CPP-D has a three-month trial of employment period).

I did send him an email asking how the employment prospect worked out, but he did not respond.

## **Alberta LTD Nurse Participant Narrative**

Our interview was conducted via Skype. C. is a middle-aged woman who formerly worked as a Nurse-Therapist in community mental health clinics as part of a region-wide multidisciplinary team encompassing three communities some distance apart. She is currently living in her own home with her husband, and two mentally disabled boarders, both receiving AISH, who are like family to her. They pool their resources. Her husband lives with ADHD and depression and was unemployed for a long time (he is currently employed taking care of C.). They did not have children. C. runs a volunteer non-profit disability advocacy group based in her community, helping people apply for disability benefits.

C. had an MVA in January 1990 while driving to one of the mental health clinics, when she hit black ice, rolled the vehicle (her own) and ended up in the ditch of the oncoming lane. She walked away from the accident, but aggravated an existing spinal fracture (L5-S1) and a sustained a brain injury, which made it difficult for her to sort out how to proceed. At first, because she was driving her own vehicle (as part of her employment), she was required to first make a claim with her own motor vehicle insurance. But part of her vehicle insurance is covered by her employer (Alberta Health Services) because occasionally she had to transport patients. As she did not mention in the interview if she made these claims or if they were successful, I suspect they were not primary or relevant. C. was off work for five days.

Shortly after going on sick leave, C. phoned her supervisor and suggested that they needed to open an AB-WCB claim. But her supervisor — the regional clinic manager— disagreed. C. did not have any union members to consult at her job site, nor was there an on-site manager, and recounts the sequence of events as follows:

And I said, “I really think this is work time.” And she's like, "No I don't think so." So then she says that … she sorta disagrees, right? So I was a little more strident and say, "This is the law that we have to report this. And I think you should consult with somebody 'cause this is a work loss … a time loss injury." So she goes and consults somebody and bingo, bongo, bango, he’s like, "Yes it is. And now we're late. And now we're all in trouble," right?

R: You’re late for applying you mean?

Late for reporting. It's a time loss injury. You have to report it, right? Twenty-four hours. We were maybe thirty-six—we were over time.

C. tells me they had to scramble to get it reported, especially given it all had to be done in paper form, not electronically. The claim was submitted two days after the accident. Apparently, a long-term disability application was completed and sent also at this time, but was denied at the time. C. was off work for five days following the accident and when she returned to work (for three weeks) she felt quite foggy. At the same time, she requested time off so she could attend the funeral of a fellow veteran in Edmonton. Her supervisor, a psychologist, noticed something about C.’s demeanour and suggested she get counselling. C. had already booked a session with the EAP therapist because she was having trouble sleeping after the accident: she also had her first panic attack about three days after the accident. She describes her situation as follows:

And I was really anxious and I just knew that something wasn't right. Like even the day of the accident I knew something was horribly wrong but I couldn't pinpoint what. And I had an appointment booked — I already had it booked even before (names friend)'s death. I knew something was wrong. I just didn't know what … I knew something was off. It was like … there were two … I don't know if you ever read Sylvia Plath but there's a line in one of her poems that goes, "There are two of me now." And there was the me that was going through the motions of work, and there was the me that there was something very, very off, right? [uh huh]. And just not sleeping, anxious … um … just barely holding on and I was agitated and anxious. You know … it was bad.

C. continued to see the EAP therapist, who she began seeing three weeks after the accident, for six months. Before she saw this therapist for the first time, he had spoken with her supervisor, a colleague, and they both agreed she should have time off work ( 6 months). Paperwork for a short-term disability claim (with Great West Life) had begun in this early period. Interestingly, C. did not receive any compensation or benefits from AB-WCB until two weeks before she returned to work six months later. During this period C. tells me she had “virtually no income.” She used up all her sick leave, but after that didn’t apply for EI sick leave because she was supposed to be receiving AB-WCB wage loss replacement, and was too embarrassed to apply for social assistance. As we talk, she has a vague memory of receiving short-term disability benefits, but knows for sure there was a period of not receiving any income at all, closer to the end of the six-month leave. (it may be possible her short-term disability benefit was withheld because of her AB-WCB claim). C. tells me she couldn’t pay her rent and so spoke with an AB-WCB supervisor about her situation, whereupon shortly after doing so she began to receive cheques from WCB, two weeks before she was to return to work. The cheques were not backdated from the time of her injury. She also tells me she ended up with an overpayment to WCB. Apparently, she had disclosed being a sexual abuse survivor on her WCB application form, which they considered a pre-existing condition.

The decision that she was well enough to return to work (at six months) was made by the EAP therapist, but C. did not believe she was well enough to do so, especially since she became aware that she has developed multiple personality disorder. C. tells me her initial diagnosis was depression, but when therapy is terminated it was dissociative identity disorder, not otherwise specified (DDNOS). She believes the therapist failed to recognize and address the PTSD she was experiencing, and was insulted when he suggested that she and her husband should have a trial separation. Nonetheless, C. returned to work for a year (June 1990-July 1991), and subsequently left in July 1991 on a long-term disability leave, which she is currently on. During that return to work she was “work hardening,” which included a modified schedule for a short period before she went back on a full-time schedule, prior to leaving on LTD.

Upon C.’s return to work, AB-WCB continued to pay for physio for her injured back (for 2 or 2.5 years total), and continued to monitor her. Interestingly, this included self-reports and reports from her GP and psychologist. While she was receiving the back physio, but no wage replacement, sometime in 1991, a review was done by a nurse contracted by WCB, which included interviews with her husband, her in-laws and two friends to determine how disabled she was in her daily life compared to before the accident. They also wanted to interview C.’s family, including her parents who had been her primary abusers, which C. refused.

C. was also seen by an AB-WCB-contracted neuropsychologist, who did not believe in DDNOS and diagnosed C. with anti-social personality disorder, and post-concussion syndrome. Subsequent psychiatric testing refuted the anti-social personality disorder diagnosis. Strangely, he suggested her ability to tell her story had undermined her eligibility for AB-WCB. He prescribed ten therapy sessions covered by AB-WCB. When asked C. tells me she thinks AB- WCB was finished with her at the two- or three-year point, but does not recall the exact time frame. AB-WCB did not notify her of the termination of her benefits (physio); she discovered this when presented with a large bill at the physio clinic, which she was unable to pay. Previously, AB-WCB paid for C.’s physio directly so this came as a shock. In response C. contacted her AB-WCB case manager, who without notification had also changed, but was unsuccessful in her efforts to change their decision to bill her for services. Given she was having trouble making ends meet — it happened at a time when her husband was not working — C. was very upset about receiving this physio bill. To her credit she tells me how she understands AB-WCB claims currently

I was on WCB in the time when their practices were so poor. The system now has been overhauled happily because of the experiences of myself and many other injured workers, so that it is much better now. My husband was on WCB for work-related injuries and they have a much better system to flow people through now … that's much more transparent, much more above board, and people are rehabilitated now in much fairer, much more efficiently-adjudicated ways. And there's letters, flow charts, this is where you are in your claim, this is where you are now, this is where we hope you will be. (names husband) had a tendonitis injury from repetitive strain, and he was immediately put on physio, his income was replaced immediately. He got a letter, a progress report … he was in immediate physio, and he never had any problems with either his coverage or his physio. And he was immediately put through, and every time there was a periodic review of his claim, he received a letter, and there was a flow chart that says this is where you are in the process, and everything was moved through. So it's important because twenty years later when he went on WCB it was a lot fairer and a lot easier.

C. did return to work in 1991 but really was very ill with DDNOS, PTSD and depression. She was having trouble sleeping, but managed to receive a good performance review after being back for six months. She did reveal to her supervisor at the time that she felt “shaky” and her supervisor remarked, “I wish you hadn't told me that, because now I have to decide whether or not I want a brain injured therapist on my staff.” C. believes this comment was a violation of her rights, but didn’t act on it. At this point C. had come to realize that the voices in her head were not “normal” as she had believed since she was a young child, and that she really needed more therapy. Also, the top of her lip was paralyzed. In May 1991, C. has a conversation with her therapist who said, “I think we’re looking at multiplicity” but had no experience diagnosing or treating it. He consulted with a colleague who agreed with him, and recommended she leave work and apply for long-term disability benefits. When I ask when the LTD applications would have been submitted she tells me

They would have gone in … see I had been interacting both with short- and long-term disability and WCB over the whole course of that 2 year period. So they had their eyes on me that whole time, right? [right] Because I got denied long-term disability the first time … you’re supposed to have a long-term disability top up, right? So when I was off the first six months I didn't get the top-up.

C.’s LTD claim was resubmitted and included information from

The family doctor, my psychologist and a psychiatrist. The psychiatrists rotated. I rotated through tons of consulting psychiatrists. And the reason for that was at the time you had to have a psychiatrist … if you had a psychologist you had to have a psychiatrist rubber stamp it. And they didn't care what psychiatrist it was.

C.’s claim is approved and she begins receiving LTD benefits almost right away. She believes the taxable, non-indexed benefit was calculated against 80% of her pre-disability earnings. She was not required to apply for CPP-D until she was past the two-year mark. She initially resisted this because she thought (mistakenly) that if she received CPP benefits before retirement she would use up the amount from CPP she would receive at retirement. She was so terrified of applying she delayed it to the point that GWL threatened to withhold some of her benefit until she did so. A phone call to CPP reassuring her that she would receive her full retirement benefit eased her mind enough to apply. She applied for CPP-D successfully, and her basic CPP-D amount is clawed back from her benefit; she retains the indexed portion.

C. receives extended health, dental and prescription benefits (for herself and her husband), and is accruing pensionable years of service while on benefits, with the employer contributing 100% to the pension, rather than 50:50 while she was working. Her employer continues to pay life insurance on her behalf while on LTD. Occasionally, over time she has received a marginal increase in her benefit and tells me she thinks it is because the union and the employer, “sort of recognize the income doesn't keep pace with the cost of living.” C. tells me she would “be destitute” without her LTD benefit, which she says keeps her “in part of the poor middle class.” She has complex medical needs that are not covered by her LTD benefit, including dressings, a bath chair, a grab bar, and a wheelchair. She reveals she had a large benign but painful tumour removed from her ovary, followed by the removal a year later of an equally painful one on her other ovary. But things did not go smoothly with her LTD benefit at the time — she was cut off for two months

Because when a report was required my family doctor … who has been my doctor since 1989, who has never failed to do a report, did his report. But he had bought a new practice, and he had a very passive-aggressive new clerical person who didn't tell him the policy of the practice — didn't even tell him or me — that prepayment was required for the report. And that report sat on my file for three months. I go to pay my rent and there's no money in the bank. And I ended up having to go on welfare for two months. And thank god that I was living in a small town in which the social worker was my colleague. He helped me and I phoned him when the money wasn't in by the middle of the month for the next month.

Getting reinstated was a matter of getting the report completed by the doctor and submitted to GWL, during which time C. applied for social assistance with the help of a colleague who was a social worker. She expresses regret that she was unaware she could have applied to social assistance during the six months she hadn’t been paid by AB-WCB, especially given how “destitute” she was, and the negative effect on her credit rating (interestingly, previously she told me she didn’t apply for social assistance because she was too embarrassed). She had also used the savings she had to pay for psychological services. During this delay in her LTD benefits she applied for CPP-D.

She describes the LTD application process, for which she received help from a friend because she was brain injured and emotionally distraught at the time

We did it longhand with a pencil. We used pencil so we could erase. We photocopied it so that I had the original and everybody else had copies. And I did the copies so that they would show up with dark ink, right? It took many, many, many pages. And my friend did all the writing.

She tells me the LTD application form (and process?) was more complex than the WCB forms

The LTD was very stringent. They said if you even miss a fax number your application will be rejected. The one other thing that I did know from some research in the forms is that you could put any attachments … like to put things in your own words … so I did a lot of, "Please see attached." Because the forms didn't have enough space, right?

C. is a member of the Alberta Union of Public Employees, her employer is Alberta Health services and Great-West Life is the insurance carrier. Interestingly, her benefit cheques come from the employer — “we are still treated as employees” — she receives pay stubs from the employer. Unfortunately, the employer issued CRA T4s which treated the disability benefit as employment income, which resulted in C. being reviewed by CPP-D (because CRA records indicated she was working).

I ask about the two year “any occupation” rule and what might have happened to C. during this period of reassessment, and she tells me

Well there is "fit for gainful criteria" [employment], which in our shop was anything for which you had education or experience. And there's also an earnings criteria. Which used to be up to 70% of your pre-employment salary.

Somewhere along the line C. had a psychiatric review by a consulting psychiatrist (as part of a requirement of the LTD plan) who assessed her as “fit for gainful.” But C. had numerous other medical conditions that would have precluded this happening, and was frightened about losing her benefits nonetheless. She phoned GWL to speak with the person who had signed the last letter sent to her. (presumably a Disability Benefits Administrator), and explained the situation. GWL reassured her that she was not going to be disallowed benefits or forced back to work.

C. receives personal care and home support through the Alberta Health Services Self-Managed Care program. Her husband is her paid caregiver through the program.

1. The Market Basket Measure (MBM) calculates low income based on the regional cost of goods and services individuals and families require to meet their basic needs and establish a modest standard of living. These include such things as food, clothing, shelter, transportation, and household utilities. If a working individual or a family’s income after taxes, payroll deductions, child support and out-of-pocket medical expenses falls short of the estimated cost of the ‘basket’ of goods and services available in their particular community, they are considered to be living below the official poverty line (Kimpson, in press). [↑](#footnote-ref-2)