Employer Statement - Accident Benefit Plan

Please return this completed form and supporting documents to:

The Wawanesa Life Insurance Company
Attn: Life Claims Department
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
For inquiries, please call 1-844-318-0411
Fax: 1-855-496-3028 Email: wawanesalife-claims@wawanesa.com
wawanesalife.com

Employee Contact Information

First Name: _____ Last Name: _____

Policy Number: _____ Date of Birth (mm/dd/yyyy): _____

Telephone Number: _____ ◯ Home ◯ Cell

Email: _____

Employee Employment Information

Date of Hire (mm/dd/yyyy): _____ Employee Classification: ◯ Temporary ◯ Full-Time ◯ Contract

Last day worked (mm/dd/yyyy): _____ Date of Disability or Death (mm/dd/yyyy): _____ ☐ N/A (no absence from work)

Has the employee returned to work? ◯ Yes ◯ No If yes, provide the return to work date (mm/dd/yyyy): _____

Employee Job Information

Employee position/title: _____ Work schedule (day/night/rotation): _____

Number of hours worked per week: _____ Monthly income estimate ($): _____

For Disability Claims, is the employee's job description included? ◯ Yes ◯ No

If the job description is not available, please complete the section below:

◯ Vehicle Operator or Manual Duties ◯ Administrative and/or Office

Employee's main job tasks: _____

Check all that apply: ☐ Reaching above shoulder height ☐ Bending or Crouching ☐ Walking

Amount of lbs employee is required to lift or carry: _____ ☐ N/A

Amount of lbs employee is required to push or pull: _____ ☐ N/A

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Employer Comments

Please provide any additional information that you believe should be considered in assessing this claim:

Employer Contact Information

First Name: _____ Last Name: _____

Title: _____ Date form completed (mm/dd/yyyy): _____

Email: _____ Telephone Number: _____

_____

Employer's Signature

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