



# SHORT-TERM DISABILITY PLAN SPONSOR STATEMENT

Please return this completed form and supporting documents to:

Wawanesa Life - Claims  
236 Carlton St, Winnipeg, MB R3C 1P5  
For inquiries, please call: 1-844-318-0411, #4  
Fax 1-855-496-3028  
Email: WawanesaLife-claims@wawanesa.com  
Website: wawanesalife.com

## PLAN SPONSOR IDENTIFICATION

Group Plan # \_\_\_\_\_ Account # \_\_\_\_\_  
Plan Sponsor \_\_\_\_\_ Address \_\_\_\_\_  
Street City Province Postal Code  
Phone Number \_\_\_\_\_ Email \_\_\_\_\_ Fax: \_\_\_\_\_  
Leader's Name \_\_\_\_\_ Branch \_\_\_\_\_ Phone Number \_\_\_\_\_ Email \_\_\_\_\_  
HR Rep. Name and Title \_\_\_\_\_

## PLAN MEMBER IDENTIFICATION

Plan Member \_\_\_\_\_ Plan Member ID \_\_\_\_\_  
Last Name First Name Initial  
Email \_\_\_\_\_ Phone Number \_\_\_\_\_

## EARNINGS INFORMATION *if WCB/WSIB/CSST claim, attach initial report of illness or injury and award notice*

Plan Member's salary as of last day worked \_\_\_\_\_  Hourly  Monthly  Annually  
Effective date of salary \_\_\_\_\_  
(yy/mm/dd)  
Has a claim been filed with another wage loss provider?  Yes  No  
If 'Yes', select provider  WCB/WSIB/CSST  CPP/QPP  Auto  Other, specify \_\_\_\_\_  
Date filed \_\_\_\_\_ Decision \_\_\_\_\_ Amount \_\_\_\_\_  
(yy/mm/dd)

## EMPLOYMENT INFORMATION

Effective date of insurance \_\_\_\_\_ Date of hire \_\_\_\_\_ Last day worked \_\_\_\_\_ Hours Worked \_\_\_\_\_  
(yy/mm/dd) (yy/mm/dd) (yy/mm/dd)  
Salary or sick leave benefits paid to: \_\_\_\_\_ If laid off or on leave, date of commencement \_\_\_\_\_ and recall \_\_\_\_\_  
(yy/mm/dd) (yy/mm/dd) (yy/mm/dd)  
Employee Classification:  Full Time: Hours per week \_\_\_\_\_  Part Time: Hours per week \_\_\_\_\_  
 Temporary  Seasonal  Contract  
Please explain the Plan Member's typical work week (eg. Monday to Friday, 8 am to 5 pm) \_\_\_\_\_  
Reason for absence:  Medical  Leave of absence  Dismissed  Temporary lay-off  
 Quit  Work related accident or sickness  Strike  
 Retired  Other \_\_\_\_\_  
Has the Plan Member returned to work?  Yes  No If 'Yes', please indicate date \_\_\_\_\_ If 'No', is return to work date known \_\_\_\_\_  
(yy/mm/dd) (yy/mm/dd)

**JOB INFORMATION**

Plan Member's position/title \_\_\_\_\_

Effective date of position \_\_\_\_\_  
(yy/mm/dd)

What department does the Plan Member work in? \_\_\_\_\_

What are the essential duties of this job and what percentage of time do they involve?

| Duties | Percentage (%) |
|--------|----------------|
|        |                |
|        |                |
|        |                |
|        |                |

For questions A, B, and C, frequency is defined as follows: Occasionally: 1-20%; Frequently: 21-50%; Always: 51+ %; N/A: Not Applicable

**A. Work environment** – Does the involve:

|                      |                            |                            |                            |                              |
|----------------------|----------------------------|----------------------------|----------------------------|------------------------------|
| Frequency            | <input type="checkbox"/> O | <input type="checkbox"/> F | <input type="checkbox"/> A | <input type="checkbox"/> N/A |
| Outside              | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |
| Extreme cold or heat | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |
| Toxic fumes          | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |

|                           |                            |                            |                            |                              |
|---------------------------|----------------------------|----------------------------|----------------------------|------------------------------|
| Frequency                 | <input type="checkbox"/> O | <input type="checkbox"/> F | <input type="checkbox"/> A | <input type="checkbox"/> N/A |
| Damp or humid environment | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |
| Above or below ground     | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |
| Handling chemicals        | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     |

**B. Mobility** – Does the job involve:

|                      |                          |                          |                          |                          |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Standing             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climbing             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneeling or crawling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                       |                          |                          |                          |                          |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bending or crouching  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Above shoulder height | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| At shoulder height    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Below shoulder height | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**C. Strength** – Does the job require the Plan Member to carry more than:

|                  |                          |                          |                          |                          |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 50 lbs / 22.7 kg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 lbs / 9.1 kg  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 lbs / 4.5 kg  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Does the job require the Plan Member to lift more than: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 50 lbs / 22.7 kg  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 lbs / 9.1 kg   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 lbs / 4.5 kg   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Indicate any equipment used by the Plan Member (eg. Computer, drill, etc.)

| Type | Percentage (%) of day |
|------|-----------------------|
|      |                       |
|      |                       |
|      |                       |
|      |                       |

Were any modifications made in the Plan Member's job duties as a result of the condition?  Yes  No

If 'Yes', please explain and give the effective date.

\_\_\_\_\_

\_\_\_\_\_



**Comments**

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

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**PERSONAL INFORMATION CONSENT :**

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued, or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting [privacy@wawanesa.com](mailto:privacy@wawanesa.com) or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

I certify that to the best of my knowledge, the above statements are true and correct.

\_\_\_\_\_ Name

\_\_\_\_\_ Title

\_\_\_\_\_ (yy/mm/dd)

\_\_\_\_\_ Authorized Signature