Please return this completed form and supporting documents to:
Group Benefit Services
400-200 Main Street, Winnipeg, MB R3C 1A8
For inquiries, please call 1-800-665-7076

LONG TERM DISABILITY
PLAN SPONSOR STATEMENT

PLAN SPONSOR IDENTIFICATION

Group Plan #__________ Account #__________

Plan Sponsor__________

Address:__________
City/Town Province Postal Code

Telephone Number:__________ Email Address:__________

Fax:__________

PLAN MEMBER IDENTIFICATION

Plan Member__________ Plan Member ID__________
Last Name First Name Initial

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__________ (yy/mm/dd) Decision__________ Amount__________

EMPLOYMENT INFORMATION

Effective date of insurance__________ (yy/mm/dd) Date of hire__________ (yy/mm/dd)

Last day worked__________ (yy/mm/dd) Hours worked__________

Salary or sick leave benefits paid to:__________ (yy/mm/dd) If laid off or on leave, date of commencement and recall

Commencement date__________ (yy/mm/dd) Recall date__________ (yy/mm/dd)

Employee Classification: ☐ Full Time: Hours per week______ ☐ Part Time: Hours per week______

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__________ (yy/mm/dd) If 'No', is return to work date know__________ (yy/mm/dd)

JOB INFORMATION

Plan Member's position/title__________

Effective date of position/title__________ (yy/mm/dd)

What department does the Plan Member work in?__________

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JOB INFORMATION

Continued

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

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

Duties	Percentage (%)

A. Work environment - Does the job involve:

Frequency	O	F	A	N/A
Outside	☐	☐	☐	☐
Extreme cold or heat	☐	☐	☐	☐
Toxic fumes	☐	☐	☐	☐
Damp or humid environment	☐	☐	☐	☐
Above or below ground	☐	☐	☐	☐
Handling chemicals	☐	☐	☐	☐

B. Mobility - Does the job involve:

	O	F	A	N/A
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐
Reaching				
Above shoulder height	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐

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

	O	F	A	N/A
50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐

Does the job require the Plan Member to lift more than:

	O	F	A	N/A
50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐

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

Type	Percentage (%) of day

Please check the time frame that most accurately reflects the amount of time the Plan Member is required to maintain the following activities before changing position or activity

	At one time (minutes)				Per day (hours)			
	0-30	30-60	60-90	>90	0-2	2-4	4-6	6-8
Sitting	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐

How much of the Plan Member's time is spent:

Talking ______%

Writing ______%

Supervising other people ______%

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JOB INFORMATION *Continued*	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.
ADDITIONAL INFORMATION	Should it be medically supported that the Plan Member return to work on a rehabilitative basis, can such an endeavor be accommodated (*eg. gradual return to work, modified work duties, temporary basis, permanent part-time basis, temporary alternate position, permanent alternate position, etc.*). Prior to the Plan Member's return to work, are there any employment issues that need to be addressed? If yes, please explain. Please confirm the Plan Member's current employment status, if terminated, please indicate date of termination. Please provide any additional information that you believe should be considered in assessing this claim.
	I certify that to the best of my knowledge, the above statements are true and correct. Name ____________ Title ____________ (yy/mm/dd) ____________ Authorized Signature ____________

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