



Group Long Term Disability Benefit Plan Sponsor Statement

400-200 Main Street
Winnipeg, MB R3C 1A8
Toll free: 1-800-665-7076
grpdisability@wawanesa.com

Plan Sponsor Identification	Group Plan #		Account #	
	<input type="text"/>		<input type="text"/>	
	Plan Sponsor			
	<input type="text"/>			
	Address	City	Province	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone	Fax	Email		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Plan Member Identification	Last name	First name	Initial
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Plan Member ID <input type="text"/>	

Earnings Information	Plan Member's salary as of last day worked	Effective date of salary (yy/mm/dd)	
	<input type="text"/> <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="text"/>	
	Has a claim been filed with any other wage loss provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', select provider	
	<input type="checkbox"/> WCB/WSIB/CSST <input type="checkbox"/> CPP/QPP <input type="checkbox"/> Auto <input type="checkbox"/> Other, specify	<input type="text"/>	
<i>If WCB/WSIB/CSST claim, send initial report of illness or injury and award notice.</i>	Date Filed (yy/mm/dd)	Decision	Amount
	<input type="text"/>	<input type="text"/>	<input type="text"/>

Employment Information	Effective date of insurance	Date of hire	
	<input type="text"/>	<input type="text"/>	
	Last day worked	Hours worked	Salary or sick leave benefits paid to:
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	If laid off or on leave, date of commencement and recall		
	Commencement date	Recall date	
	<input type="text"/>	<input type="text"/>	
	Employment Classification:		
	<input type="checkbox"/> Full Time: Hours per week _____ <input type="checkbox"/> Part Time: Hours per week _____ <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Contract		
	Please explain the plan member's typical work week. (eg. Monday to Friday, 8 am to 5pm)		
<input type="text"/>			
Reason for absence:			
<input type="checkbox"/> Medical <input type="checkbox"/> Leave of absence <input type="checkbox"/> Strike <input type="checkbox"/> Dismissed <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Quit <input type="checkbox"/> Retired <input type="checkbox"/> Work related accident or sickness <input type="checkbox"/> Other			
Has the plan member returned to work?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', please indicate date	If 'No', is return to work date known	
	<input type="text"/>	<input type="text"/>	

Job Information

Plan Member's position/title	Effective date of position/title (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																																																																																																																									
<p>A. Work environment - Does the job involve:</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; text-align: center;">Frequency</td> <td style="width:25%; text-align: center;">O F A N/A</td> <td style="width:25%; text-align: center;">Frequency</td> <td style="width:25%; text-align: center;">O F A N/A</td> </tr> <tr> <td>Outside</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>Damp or humid environment</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Extreme cold or heat</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>Above or below ground</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Toxic fumes</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>Handling chemicals</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> </table> <p>B. Mobility - Does the job involve:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%;">Standing</td> <td style="width:50%;">Reaching</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Walking</td> <td>Above shoulder height</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Climbing</td> <td>At shoulder height</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Sitting</td> <td>Below shoulder height</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td>Kneeling or crawling</td> <td>Bending or crouching</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> </table> <p>C. Strength - Does the job require the Plan Member to carry more than:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%;">50 lbs/22.7 kg</td> <td style="width:50%;">Does the job require the employee to lift more than:</td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>50 lbs/22.7 kg</td> </tr> <tr> <td>20 lbs/9.1 kg</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>20 lbs/9.1 kg</td> </tr> <tr> <td>10 lbs/4.5 kg</td> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></td> <td>10 lbs/4.5 kg</td> </tr> </table> <p>Indicate any equipment used by the Plan Member (eg. computer, drill etc.)</p> <table style="width:100%; border: none;"> <tr> <td style="width:80%;">Type</td> <td style="width:20%;">Percentage of day</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> </table> <p>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.</p> <table style="width:100%; border: none;"> <tr> <td></td> <td colspan="4" style="text-align: center;">At one time (minutes)</td> <td colspan="4" style="text-align: center;">Per day (hours)</td> </tr> <tr> <td></td> <td style="text-align: center;">0-30</td> <td style="text-align: center;">30-60</td> <td style="text-align: center;">60-90</td> <td style="text-align: center;">>90</td> <td style="text-align: center;">0-2</td> <td style="text-align: center;">2-4</td> <td style="text-align: center;">4-6</td> <td style="text-align: center;">6-8</td> </tr> <tr> <td>Sitting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Standing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Driving</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Walking</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>How much of the Plan Member's time is spent:</p> <table style="width:100%; 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For questions A, B and C, **Frequency** is defined as follows:
Occasionally: 1-20%
Frequently: 21-50%
Always: 51+%
N/A: Not Applicable

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

[Empty box for Name]

Name

[Empty box for Title]

Title

[Empty box for Date]

Date (yy/mm/dd)

[Empty box for Authorized Signature]

Authorized Signature