



SHORT-TERM DISABILITY PLAN SPONSOR STATEMENT

Please return this completed form and supporting documents to:

Wawanesa Life - Claims
400-200 Main Street, Winnipeg, MB R3C 1A8
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.

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 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