



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

SHORT TERM DISABILITY PLAN SPONSOR STATEMENT

PLAN SPONSOR IDENTIFICATION	Group Plan # _____ Account # _____ Plan Sponsor _____ Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> City/Town Province Postal Code </div> Telephone Number: _____ Email Address: _____ Fax: _____
PLAN MEMBER IDENTIFICATION	Plan Member _____ Plan Member ID _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last Name First Name Initial </div>
EARNINGS INFORMATION <i>If WCB/WSIB/CSST claim, attach initial report of illness or injury and award notice</i>	Plan Member's salary as of last day worked _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually Effective date of salary _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd)</div> Has a claim been filed with another 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 _____ Date Filed _____ Decision _____ Amount _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd)</div>
EMPLOYMENT INFORMATION	Effective date of insurance _____ Date of hire _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd) (yy/mm/dd)</div> Last day worked _____ Hours worked _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd)</div> Salary or sick leave benefits paid to: _____ If laid off or on leave, date of commencement and recall <div style="text-align: center; font-size: x-small;">(yy/mm/dd)</div> Commencement date _____ Recall date _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd) (yy/mm/dd)</div> Employee 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 5 pm) Reason for absence: <input type="checkbox"/> Medical <input type="checkbox"/> Leave of absence <input type="checkbox"/> Dismissed <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Quit <input type="checkbox"/> Work related accident or sickness <input type="checkbox"/> Strike <input type="checkbox"/> Retired <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 _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd) (yy/mm/dd)</div>
JOB INFORMATION	Plan Member's position/title _____ Effective date of position/title _____ <div style="text-align: center; font-size: x-small;">(yy/mm/dd)</div> What department does the Plan Member work in? _____



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	Frequency	O	F	A	N/A
Outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damp or humid environment	<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"/>	Above or below ground	<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"/>	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"/>	Reaching				
Walking	<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"/>
Climbing	<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"/>
Sitting	<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"/>
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"/>

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"/>	Does the job require the Plan Member to lift more than:				
20 lbs / 9.1 kg	<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"/>
10 lbs / 4.5 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.

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

_____ Name _____ Title _____
 _____ (yy/mm/dd) _____ Authorized Signature _____