



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

Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

SHORT TERM DISABILITY PLAN SPONSOR STATEMENT

<p>PLAN SPONSOR IDENTIFICATION</p>	<p>Group Plan # _____ Account # _____</p> <p>Plan Sponsor _____</p> <p>Address: _____ <small>City/Town Province Postal Code</small></p> <p>Tel. Number: _____ Email _____ Fax: _____</p> <p>Leader's Name: _____ Branch: _____</p> <p>Phone Number: _____ Email: _____</p> <p>HR Rep. Name and Title: _____</p>
<p>PLAN MEMBER IDENTIFICATION</p>	<p>Plan Member _____ Plan Member ID _____ <small>Last Name First Name Initial</small></p> <p>Plan Email _____ Plan Phone Num. _____</p>
<p>EARNINGS INFORMATION</p> <p><i>If WCB/WSIB/CSST claim, attach initial report of illness or injury and award notice</i></p>	<p>Plan Member's salary as of last day worked _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually</p> <p>Effective date of salary _____ <small>(yy/mm/dd)</small></p> <p>Has a claim been filed with another wage loss provider? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', select provider <input type="checkbox"/> WCB/WSIB/CSST <input type="checkbox"/> CPP/QPP <input type="checkbox"/> Auto <input type="checkbox"/> Other, specify _____</p> <p>Date Filed _____ Decision _____ Amount _____ <small>(yy/mm/dd)</small></p>
<p>EMPLOYMENT INFORMATION</p>	<p>Effective date of insurance _____ Date of hire _____ <small>(yy/mm/dd) (yy/mm/dd)</small></p> <p>Last day worked _____ Hours worked _____ <small>(yy/mm/dd)</small></p> <p>Salary or sick leave benefits paid to: _____ If laid off or on leave, date of commencement and recall <small>(yy/mm/dd)</small></p> <p>Commencement date _____ Recall date _____ <small>(yy/mm/dd) (yy/mm/dd)</small></p> <p>Employee Classification: <input type="checkbox"/> Full Time: Hours per week _____ <input type="checkbox"/> Part Time: Hours per week _____</p> <p><input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Contract</p> <p>Please explain the Plan Member's typical work week (eg. Monday to Friday, 8 am to 5 pm)</p> <p>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 _____</p> <p>Has the Plan Member returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', please indicate date _____ If 'No', is return to work date known _____ <small>(yy/mm/dd) (yy/mm/dd)</small></p>
<p>JOB INFORMATION</p>	<p>Plan Member's position/title _____</p> <p>Effective date of position/title _____ <small>(yy/mm/dd)</small></p> <p>What department does the Plan Member work in? _____</p>



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

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.