Public Employees Disability Income Plan
Application for Group Long Term Disability Benefits - Employer's Statement

Important:
The completed Employer's and Employee's Statements are required before claim assessment can commence. Please ensure they are completed and submitted to Canada Life at least 8 weeks prior to the end of the Elimination Period. **Benefits may be delayed if this guide is submitted later than 8 weeks prior to the end of the Elimination Period.** Canada Life's Privacy Guidelines and applicable law allow claimants to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the claimant.

A. EMPLOYER IDENTIFICATION

Name		Group Policy Number	Division Number (if applicable)
		57402	
Address: Street & Number / PO Box	City	Province	Postal code
Telephone Number	Fax Number		

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	CL Employee I.D. Number	Social Insurance Number

C. EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY)

Last day employee was at work (MM/DD/YY)

Employment Class: Is the Employee: **Please complete each of lines a), b) and c) in full.**

a) ☐ Full time: Number of hours worked per week _____
☐ Part time: Number of hours worked per week _____

b) ☐ Temporary ☐ Seasonal ☐ Permanent ☐ Contract

c) ☐ Hourly ☐ Salaried ☐ Commissioned

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Temporary Lay-off
☐ Quit ☐ Retired ☐ Other ☐ Work related accident or sickness

Please attach copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If yes, please indicate date returned	If no, is a return to work date known?
☐ Yes ☐ No	(MM/DD/YY)	
If yes, please indicate expected date of return (MM/DD/YY)	Has employment terminated? ☐ Yes ☐ No	If yes, date (MM/DD/YY)

Pension Plan Information
Name of Pension Plan _____
Monthly employee contribution $ _____ /month _____ %
Monthly employer contribution $ _____ /month _____ %

Union Dues Information
Name of Union _____
_____ %
$ _____ /month

D. INSURANCE INFORMATION

Original effective date of the employee's basic LTD insurance (MM/DD/YY)

E. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

Employee's basic pre-disability monthly earnings (as defined in the contract):	Average monthly commissions earned in the last 12 months ending on the last day worked:	Date earnings ceased or will cease: (MM/DD/YY)	Date sick leave will cease: (MM/DD/YY)

Is the employee receiving WCB income?	Is the employee receiving auto wage replacement?	Is the employee covered for Group Life Insurance?	Is the employee covered for Group Optional Life Insurance?	If so, please provide
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	1) _____ units 2) _____ salary based

Date disability premiums paid to: (MM/DD/YY) _____ Amount of last premium: $ _____

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☐ Yes ☐ No

If yes, percentage of employment income that is tax exempt: _____ %

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ Date: _____

Name (please print): _____ Title: _____

Phone: _____ Email: _____