



- Healthcare Benefit Trust (HBT) Policy 51337
- Joint Community Benefits Trust (JCBT) Policy 59234
- Joint Facilities Benefits Trust (JFBT) Policy 59233
- Joint Health Science Benefits Trust (JHSBT) Policy 59232
- Community Social Services Employers' Association (CSSEA) HBT Policy 51367
- Healthcare Benefit Trust (HBT) Policy 50168

Claim for Long Term Disability Benefits

EMPLOYER'S STATEMENT

As the claimant's employer, you are to complete this form and submit it, along with all other required LTD claim forms, to Canada Life at:
 Vancouver: #1500 - 1055 Dunsmuir Street, Vancouver, BC V7X 1K8; or
 Langley: 2nd floor, 8700 - 200 Street, Langley, BC V2Y 0G4

Indicate which policy number applies to the employee's Long Term Disability (LTD) claim by checking the applicable box above.

PART A To be completed by Human Resources, Benefits or Payroll Department

Employer Identification *(please print)*

Name of Employer: _____ HBT Employer Division #: _____
 Contact Name: _____ Telephone #: _____ Local: _____
include Area Code
 Email Address: _____

Employee Identification

1. Name: _____
Last First Initial
 Date of Birth:

Day	Month	Year

 HBT Benefits ID No. (BID): _____
 2. Address: _____ Telephone: _____
Street & Number City Province Postal Code include Area Code

Employee Information

1. Date of Employment:

Day	Month	Year

 2. Job Title: _____
 3. Has probationary period been completed? Yes No
 4. Name of union/employee group: _____ HBT Class Code: _____
 5. Last day the employee worked regular hours & duties:

Day	Month	Year

 6. Date employee would next have worked if absence had not commenced (i.e. first day employee did not perform regular hours & duties):

Day	Month	Year

 7. Did the employee return to work during the LTD qualification period? Yes No
 If yes, *attach attendance record or summary of dates and hours worked per day.*
 Was this an early return to work (RTW) program under a collective agreement? Yes No
 If yes, was the RTW an accommodation (for own job or another job)? Yes No
 If yes, *attach a description of the accommodation including the start/end date of the accommodation.*

Earnings and Benefit Information

For all claimants: **Attach a screen print of the employee's compensation rate table or a copy of the employee's pay statement for the pay period in which the date of disability occurred.**

1. (a) Regular full-time employees - Monthly rate of pay as at last day worked: \$ _____
 (b) Regular part-time employees - Hourly rate of pay as at last day worked: \$ _____
 Unionized Healthcare and Community Social Services (CSS) employees, and full-time Community Health Workers under the CBA Collective Agreement: *Complete and attach a "Calculation of Part-time Earnings" form along with a copy of the back-up documentation used to prepare that form.*
 All other employees: Regular number of scheduled hours (excluding overtime): _____ Weekly Biweekly Monthly
 2. Date on which earnings became effective (must not be later than last day worked):

Day	Month	Year

 3. Income tax: *attach completed tax forms (TD1 & TD1BC) if LTD benefits are taxable.*

4. Isolation allowance (if applicable): \$ _____ Monthly Hourly
5. Claimants with sick leave or short term disability (STD) or STIPP (if applicable):
 Will employee have unused sick leave credits or STD or STIPP benefits after the LTD qualification period? Yes No
 If yes: Unionized healthcare and CSS employees – *complete and attach a "Sick Leave Credits Report" form*
 All other employees – indicate the date that sick leave, STD or STIPP will cease to be paid.

Day	Month	Year
- If no: All employees – indicate the date the employee will have exhausted all sick leave credits, STD or STIPP benefits:

Day	Month	Year
6. Taxable benefits (Unionized healthcare & CSS employees only): provide the following amounts (if applicable) as at last day worked:
 ▪ Employer-paid Group Life and AD&D contributions: \$ _____ /month
 ▪ Qualification differential: \$ _____ /month
7. Has LTD coverage remained in effect since the last day worked? Yes No If no, when did coverage cease?

Day	Month	Year

Offsetting Income

To prevent the claimant from incurring an overpayment of LTD benefits, it is essential that any other disability income be reported promptly. Please provide the following information as at the date this form is completed, and in the future advise Canada Life of any changes.

1. Are WorkSafeBC benefits payable for this disability? Yes No Claim Number: _____
 If yes, when did benefits start?

Day	Month	Year

 Cease?

Day	Month	Year

 What is the WorkSafeBC benefit amount? \$ _____ Weekly Monthly
 Did the employee receive a WorkSafeBC Permanent Partial Disability (PPD) award for this disability? Yes No
 If yes, date received:

Day	Month	Year

 Monthly PPD benefit: \$ _____ OR Lump Sum Settlement: \$ _____
 If WorkSafeBC has denied or terminated the claim, has the employee appealed this decision? Yes No
 Date of appeal:

Day	Month	Year

Please attach correspondence outlining any decisions to-date.
2. Has the employee claimed Canada Pension Plan disability benefits? Yes No If yes, date of application:

Day	Month	Year

 If no, give reason: _____
3. List any other sources from which the employee is claiming or receiving disability benefits as a result of this condition (e.g. ICBC for an MVA on or after May 17, 2018):

Declaration (to be signed by person completing Part A):

I hereby declare that the answers to the foregoing questions are accurate and complete.

Name (please print): _____ Authorized Signature: _____
 Date: _____ Title: _____

PART B To be completed by the employee's immediate supervisor

Disability Progression/Return to Work

1. When did the employee's disability first appear to affect his/her work?

Day	Month	Year
2. In what ways did performance on the job change as a result of the disability?

3. Were any changes made in the employee's job as a result of the disability? Yes No If "yes", please explain:

4. If the employee could return to less demanding work, would such work be available? Yes No Please explain:

Job Description

This is to be completed by the employee's immediate supervisor and is to be a description of this employee's job immediately prior to becoming absent. This information is of critical importance in assessing the disability relative to the job requirements. Attach a Job Demands Analysis, if available, for the employee's job.

1. Employee's job title as of last day worked: Department/Program:

2. How long has the employee worked in this position and type of department or program)? Years Months

3. What are the duties of this job, and how much time does each take per week:

Table with 2 columns: Duties, Hours/Day

4. Regular number of shifts worked every 2 weeks: 5. Number of hours worked in a regular shift:

6. Work environment - Does the employee's job require work in any of the following conditions?

Table with 5 columns: Question, Yes, No, Times/Day, Hours/Day

Does the job involve handling chemicals? Yes No If "yes", please explain:

7. Strength - Does the job require the employee to lift or carry:

Table with 5 columns: Question, Yes, No, Times/Day, Hours/Day

8. Mobility - Does the job involve:

Table with 5 columns: Question, Yes, No, Times/Day, Hours/Day

Does the job involve unusual motions? Yes No If "yes", please explain:

9. Other cognitive and psychological demands – Does the job involve:	Yes	No	Times/Day	Hours/Day
▪ working around or with other people	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
▪ working alone	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
▪ meeting deadlines	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
▪ direct dealings with people	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
▪ situations where making errors could have serious or life-threatening consequences	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
▪ facing confrontational situations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

10. Does the employee's job involve any undue amount of stress (e.g. extreme noise, rapid pace of work, monotony, deadlines, etc.)?
 Yes No If "yes", please explain:

11. Dexterity – How much of the employee's work requires:	▪ finger dexterity?	- right hand	_____	%
		- left hand	_____	%
	▪ hand dexterity?	- right hand	_____	%
		- left hand	_____	%
	▪ word processing?		_____	wpm

12. Vision – How much of the work requires:	▪ sharpness of vision?	- near	_____	%
		- far	_____	%
	▪ colour discrimination?		_____	%

13. Safety: Provide a brief description of safety sensitive tasks. List any other demands of this job that should be considered in assessing this disability relative to the job requirements:

14. Communication – How much of the employee's time is spent:	▪ talking?	_____	%
	▪ writing?	_____	%
	▪ supervising other people?	_____	%
	▪ number of people supervised?	_____	

15. Equipment used – Please list any office machines, tools or other equipment that the employee uses in this job:

Types of Equipment	Times/Day	Hours/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information

Please provide any additional information that you believe should be considered in assessing this employee's claim.

Declaration (to be signed by person completing Part B):

I hereby declare that the answers to the foregoing questions are accurate and complete.

Name (please print): _____ **Authorized Signature:** _____
Phone: _____ **Date:** _____
Department: _____ **Title:** _____