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 the appropriate office:

- Calgary Disability Management Services: calgary.dmso@canadalife.com
- Langley Disability Management Services: langley.dmso@canadalife.com
- Vancouver Disability Management Services: vancouver.dmso@canadalife.com

If you are unable to email, documentation may be submitted by mail and should be directed to:
The Canada Life Assurance Company
PO Box 1055, Winnipeg, MB R3C 2X4

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 #:** _____ (include Area Code) **Local:** _____

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: _____

3a. Has probationary period been completed? ☐ Yes ☐ No 3b. If yes, date of completion: _____

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 STIIP 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 STIIP 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: _____

Employee's Name: **HBT Benefits ID No. (BID):**

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:

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?

	Yes	No	Times/Day	Hours/Day
▪ outside?	☐	☐		
▪ in extremes of cold or heat?	☐	☐		
▪ in a damp or humid environment?	☐	☐		
▪ in a dusty or unventilated environment?	☐	☐		
▪ in toxic fumes?	☐	☐		
▪ above or below floor level?	☐	☐		

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

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

	Yes	No	Times/Day	Hours/Day
▪ over 50 pounds?	☐	☐		
▪ 20 – 50 pounds?	☐	☐		
▪ 10 – 20 pounds?	☐	☐		
▪ 5 – 10 pounds?	☐	☐		
▪ under 5 pounds?	☐	☐		

8. Mobility – Does the job involve:

	Yes	No	Times/Day	Hours/Day
▪ sitting?	☐	☐		
▪ standing?	☐	☐		
▪ walking?	☐	☐		
▪ climbing stairs?	☐	☐		
▪ climbing ladders?	☐	☐		
▪ driving?	☐	☐		
▪ remaining in one position for more than one hour?	☐	☐		
▪ reaching: above shoulder height?	☐	☐		
at shoulder height?	☐	☐		
below shoulder height?	☐	☐		
▪ bending or crouching?	☐	☐		
▪ kneeling or crawling?	☐	☐		

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	☐	☐		
▪ working alone	☐	☐		
▪ meeting deadlines	☐	☐		
▪ direct dealings with people	☐	☐		
▪ situations where making errors could have serious or life-threatening consequences	☐	☐		
▪ facing confrontational situations	☐	☐		

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:** _____