Government of Canada / Gouvernement du Canada

Claim for Disability Insurance
Employer's Statement
Policy No. 12500-G

PROTECTED *once completed*

This form has two parts.

Part 1 asks for information on the employee's employment and coverage status. **This part must be completed by the Human Resources Officer.**

Part 2 asks for information on the employee's specific job duties. **This part must be completed by the employee's immediate supervisor or manager. Please attach a current job description.**

Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), must receive this form before they can assess the claim. Please send it and the fully completed Employee's Statement to Superannuation Directorate at least 8 weeks before the end of the elimination period to avoid delay in payment of benefits.

To avoid overpayment of benefits, you must advise the Insurer immediately when the employee returns to work.

PART 1: EMPLOYMENT AND INSURANCE INFORMATION

Employer information

Department or Organization Name			
Full Address			
City	Province	Postal Code	Telephone No. ( )
Pay Office	Dept. Alpha Code	Paylist	Bargaining Unit Denominator (BUD) No. / Classification No.

Employee information

Last Name	Given Name		Maiden Name (for Quebec residents)
Street Address		Date of Birth / /	Proof of Age Attached ☐ Yes ☐ No
City	Province	Postal Code	Home Telephone No. ( )
Superannuation No.		Certificate Number CG -	

Coverage information

1. Last date of entry into the federal Public Service? Day / Month / Year

2. Date Disability Insurance (DI) coverage became effective? Day / Month / Year

3. Has this insurance coverage ever been terminated? ☐ No ☐ Yes If yes, give date and reason together with date of reinstatement:

_____

4. **a)** Amount of last DI Premium deducted from employee's salary **$**

b) Month and year last DI Premium deducted Month Year

Employment information

1. Employment status when last hired (Check one.)

	Full-time	Part-time
Indeterminate	☐	☐
Term of 6 months or less	☐	☐
Term of more than 6 months	☐	☐
Seasonal	☐	☐
Other (specify) _____	☐	☐

2. Location of Employment: ☐ Office ☐ Home ☐ Elsewhere (Explain below)

_____

Claim for Disability Insurance Employer's Statement
Policy No. 12500-G

Employment information (continued)

3. What was the employee's job title on the last day worked?

4. From what date has the employee been assigned this position? **(Attach current job description.)** Day / Month / Year

5. a) How many hours was the employee assigned to work per week?

b) On what date were these assigned hours authorized? Day / Month / Year

c) If the employee is working part-time, what are the equivalent full-time hours?

d) If the employee is working part-time, what is the equivalent full-time salary? **$**

6. What was the last day the employee was actively at work? Day / Month / Year

7. Did the employee leave work for medical reasons? ☐ No ☐ Yes

8. If the employee is absent for any reason other than illness or disability (e.g. maternity leave), please give details.

9. Was the employee on leave without pay? ☐ No ☐ Yes If yes, from what date? Day / Month / Year

10. a) Has the employee been permanently struck off strength? ☐ No ☐ Yes If yes, on what date? Day / Month / Year

b) Give details:

11. Has the employee returned to work? ☐ No ☐ Yes If yes, on what date? Day / Month / Year

12. If known, what is the anticipated date of return to work? Day / Month / Year

13. Is the employee's regular job still available? ☐ No ☐ Yes If no, give reason:

14. If the employee changed positions or assignments during the 12 months immediately before the last day worked, list the previous positions or assignments. Please also give the reasons for the changes and the effective dates of the changes.

15. Please give dates and details of any sick leave, maternity leave or other leave taken during the 12 months before the illness or injury began. Use extra sheets, if necessary.

Type of Leave	Details	Start Date	End Date	No. of Working Days

16. To your knowledge, is the employee now working elsewhere? ☐ No ☐ Yes If yes, give details.

Claim for Disability Insurance Employer's Statement
Policy No. 12500-G

PROTECTED *once completed*

Earnings and benefit information If any of the questions do not apply, please put N/A in the blank space.

1. Give details of the employee's **insured salary and allowances** as at the last day of the elimination period. (Use the proportional rate for employees working less than full-time hours.)

Authorized Rate of Pay	Rate	Yearly
Salary	$ per	$
Insured Allowance(s) - specify type(s)	**Rate**	
	$ per	$
	$ per	$
	$ per	$
	Total	$

2. What is the total adjusted annual salary? (If total salary is not a multiple of $250, adjust it up to the next higher multiple of $250.) **$**

3. What are the total personal federal income tax exemptions from the last TD1? (For Quebec residents, use the last TPD1.) **$**

4. For Quebec residents, what are the total personal provincial income tax exemptions from the last MR19? **$**

5. a) Does the employee have unused sick leave on the last day actively at work? (Include credits earned during the elimination period.) ☐ No ☐ Yes If yes, how many days? _____

b) Has the employee been granted advanced sick leave? ☐ No ☐ Yes If yes, how many days? _____

6. What was/is the last date of paid sick leave? (5a + 5b) Day / Month / Year

7. If the employee was/is not allowed to use all available sick leave credits, give the date they would have ended and give the reason(s) why they were not paid. Day / Month / Year

8. Was any other type of paid leave granted? ☐ No ☐ Yes If yes, give details:

9. On what date will the paid leave end? Day / Month / Year

10. What is the last day of the elimination period? (The later of 13 weeks after the illness or injury began or the date the sick leave credits (5a + 5b) end.) Day / Month / Year

Other disability income information

1. Except for PSSA entitlements, do you know of any other benefits provided by reason of the disability under any of the following:

		No	Yes	Don't Know
a)	Other group insurance (including that available through membership in an association)	☐	☐	☐
b)	The Canada or Quebec Pension Plan	☐	☐	☐
c)	Other Government Plans	☐	☐	☐
d)	Auto Insurance	☐	☐	☐

If yes, and NOT YET APPROVED, please give details under "Remarks" and include the source, nature, date of application, expected commencement date of benefits and monthly amount, if known.
If yes, and APPROVED, attach a copy of the official advice.

Remarks

Claim for Disability Insurance Employer's Statement
Policy No. 12500-G

PROTECTED *once completed*

Workers' Compensation

1. Is the employee entitled to claim workers' compensation benefits? ☐ No ☐ Yes

2. a) Has the employee applied? ☐ No ☐ Yes — If yes, has a decision been made? ☐ No ☐ Yes

b) What is the amount of the benefit received or expected? (per week) **$**

c) When did (or will) the benefit start? Day / Month / Year

d) When did (or will) the benefit end? Day / Month / Year

Declaration for Part 1

The information given in Part 1 of this form is true and complete according to our records.

Name of Designated Officer (Please print.)	Title	Telephone No. ( )
Signature	Date	Fax No. ( )

PART 2: INFORMATION ABOUT EMPLOYEE'S DISABILITY AND JOB

(to be completed and signed by employee's immediate supervisor or manager)

Information about the disability and rehabilitation

Attach extra sheets, if necessary.

Experience has shown that many employees who are disabled could be working productively if help and encouragement towards this goal were provided. If such an employee does not work, there can be a very real deterioration in the employee's motivation or actual capacity to resume productive work. Where the Insurer feels that the claimant is a suitable candidate for rehabilitation, representatives of the Insurer's Rehabilitation Unit will contact the employing department so that their efforts may be combined to encourage and accommodate the employee. The DI Plan Board of Management and the Treasury Board of Canada Secretariat, on behalf of the policyholder, strongly support the principle of rehabilitation and the efforts of departments, agencies and the Insurer, to return employees to suitable productive work.

Please identify the department or agency official whom the Insurer should contact if the claimant is considered capable of rehabilitation.

Name	Title
Address	Telephone No. ( )

1. Please describe the main duties of this employee's job and what percentage of each work week is normally dedicated to each duty. (If the attached current job description includes this information, you do not have to answer this question.)

Duties	Percentage of work week

2. When did the employee's illness or injury first appear to affect his or her work? Day / Month / Year

Claim for Disability Insurance Employer's Statement
Policy No. 12500-G

Information about the disability and rehabilitation (continued)

3. From your observations, did the employee's ability to perform his/her job change?

☐ No
☐ Yes If yes, explain.

4. Were any changes made in the employee's job as a result of the illness or injury?

☐ No
☐ Yes

If yes, what changes were made and when were they made?

5. If the employee could return to work on a reduced hours basis, or with a change in duties, would a position be available?

☐ No Give reasons:

☐ Yes Give details:

Physical work environment and job activities

1. Does the employee's job require work in any of the following conditions?

outside	☐ No ☐ Yes	If yes, what percentage of time?
in extremes of cold or heat	☐ No ☐ Yes	If yes, what percentage of time?
in a damp or humid environment	☐ No ☐ Yes	If yes, what percentage of time?
in a noisy environment	☐ No ☐ Yes	If yes, what percentage of time?
in a dusty or unventilated environment	☐ No ☐ Yes	If yes, what percentage of time?
around toxic fumes	☐ No ☐ Yes	If yes, what percentage of time?

2. Does the employee's job involve handling chemicals?

☐ No
☐ Yes

If yes, please list the chemicals below.

Physical work environment and job activities (continued)

3. During the employee's normal routine, what percentage of time does the job require the employee to lift or carry the following weights?

	Never	1 to 25%	26 to 50%	51 to 75%	76 to 100%
more than 50 lbs / 22.7 kg	☐	☐	☐	☐	☐
more than 20 lbs / 9.1 kg	☐	☐	☐	☐	☐
more than 10 lbs / 4.5 kg	☐	☐	☐	☐	☐

4. During the employee's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	26 to 50%	51 to 75%	76 to 100%
walking	☐	☐	☐	☐	☐
climbing	☐	☐	☐	☐	☐
driving:					
daytime	☐	☐	☐	☐	☐
night-time	☐	☐	☐	☐	☐
reaching:					
above shoulder height	☐	☐	☐	☐	☐
at shoulder height	☐	☐	☐	☐	☐
below shoulder height	☐	☐	☐	☐	☐
bending or crouching	☐	☐	☐	☐	☐
kneeling or crawling	☐	☐	☐	☐	☐

5. How much time is the employee required to maintain the following activities before changing position or activity?

	0 to 30 minutes	31 to 60 minutes	61 to 90 minutes	more than 90 minutes
sitting at one time	☐	☐	☐	☐
standing at one time	☐	☐	☐	☐
driving at one time	☐	☐	☐	☐

6. During the average day, what are the number of hours the employee spends in the following positions or activities?

	0 to 2 hours	3 to 4 hours	5 to 6 hours	7 to 8 hours
sitting	☐	☐	☐	☐
standing	☐	☐	☐	☐
driving	☐	☐	☐	☐

7. What percentage of the employee's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

Claim for Disability Insurance Employer's Statement
Policy No. 12500-G

Physical work environment and job activities (continued)

8. Please list any machines, tools, or other equipment that the employee uses in the job. You may list either the number of times per day the equipment is used, or the percentage of time spent using the equipment, whichever is more applicable.

Type of equipment	No. of times per day OR percentage of time

Additional information

Please provide any additional information that may be relevant to this claim that has not been previously provided.

Declaration for Part 2

To the best of my knowledge, the information given in Part 2 of this form is true and complete.

Name (Please print.)	Title	Telephone No. ( )
Signature	Date	Fax No. ( )

PART 3 - TO BE COMPLETED BY SUPERANNUATION DIRECTORATE

Statement by Superannuation Directorate

1. Is there an entitlement under PSSA? ☐ No ☐ Yes

If yes, is it a monthly annuity? ☐ No ☐ Yes If yes, Amount $ | Effective date:

Is it a lump sum? ☐ No ☐ Yes If yes, If yes, is it a ☐ ROC? ☐ TV? | Amount $

Date paid: / / | What is the monthly equivalent, if applicable? $ | Effective date: / /

2. Was a Declaration of Personal Insurability completed in connection with the Application for Disability Insurance? ☐ No ☐ Yes

3. Subdivision No.

4. Number of years of pensionable service

5. Was there a break in service? If so, give full details below.

Remarks

For Manager, Insurance Section, Superannuation Directorate

Name (Please print.)	Telephone No. ( )
Signature	Day Month Year / /

The information you provide in this form is collected under the authority of the Treasury Board for the administration of the Disability Insurance Plan and for use by the Insurer in the assessment of the disability claim. Personal information will be protected under the provision of the *Privacy Act*. Personal information that you provide about this individual may be accessible to him or her under the *Privacy Act.* This information will be stored in Personal Information Bank number PSE 901 and PWGSC-PCE-703.