

Group Benefits

Plan Employer Statement

Short Term Group Disability Claim

- To be completed by the plan sponsor.
- Please print clearly and answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- Provide the plan member with a Member Statement, GL4590E(4096)(6089), and an Attending Physician's Statement, GL4587E(4096)(6089), for the family physician or attending specialist. Ask the plan member to complete the "Patient authorization" section at the top of the Attending Physician's Statement, GL4587E(4096)(6089), on page 1 before they take it to their physician.

Return completed form to: **Prairie Teamsters Admin. Services**
209-7260 12 ST SE, Calgary AB T2H 2S5
Telephone: (403) 252-6924 Fax: (403) 253-3231
or
Manulife Financial Group Benefits, Attention: Disability Claims
PO Box 4217 STN C, Calgary AB T2T 5N1
Telephone: 1-800-561-1400 • (403) 234-9440 Fax: (403) 263-5169

1 Plan employer	Plan contract number	Division number	Company name

2 Plan member identification	Name (last, first, initial)		<input type="radio"/> Male
			<input type="radio"/> Female
	Social Insurance Number	Class	Date of birth (dd/mmm/yyyy)

3 Plan member information	Date of hire (dd/mmm/yyyy)	Date insured (dd/mmm/yyyy)	
	Plan member's job title		
	Plan member's work hours?		
	<input type="radio"/> Full-time HRS/WK _____ <input type="radio"/> Part-time HRS/WK _____ <input type="radio"/> Shift work SHIFTS/WK _____ <input type="radio"/> Other HRS/WK _____		
	Date last worked (dd/mmm/yyyy)	Number of hours worked that day	Next scheduled work day/shift prior to disability
Reason plan member stopped working			
<input type="radio"/> Illness <input type="radio"/> Injury <input type="radio"/> On layoff <input type="radio"/> Leave of absence <input type="radio"/> Dismissed <input type="radio"/> Resigned <input type="radio"/> Strike <input type="radio"/> Other _____			
Has the plan member returned to work? <input type="radio"/> Yes <input type="radio"/> No			
If yes, please provide (dd/mmm/yyyy) date returned to work.		If no, please provide (dd/mmm/yyyy) expected return date.	
Has coverage terminated? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please state when and reason why.</i>			
Date coverage terminated (dd/mmm/yyyy)	Reason for termination of coverage		

4 Workers' compensation information	Is the current condition due to a work related accident or illness? <input type="radio"/> Yes <input type="radio"/> No		
	If yes, has a claim been filed with any type of workers' compensation board? <input type="radio"/> Yes <input type="radio"/> No		
	If no, please provide reason		
	Please provide a copy of the Accident/Illness report and:		
	Workers' compensation board contact name*	Telephone number	Fax number
	Claim number	Date benefit commenced (dd/mmm/yyyy)	Date benefit ceased (dd/mmm/yyyy)
What is the current status of the application? <input type="radio"/> Pending <input type="radio"/> Approved <input type="radio"/> Declined			
* Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission de la santé et de la sécurité du travail (CSST).			

5 Job description

What are the primary duties of the plan member's job? (e.g. operate machinery, supervising responsibilities, customer service duties, maintain mechanical equipment, use a computer, etc.)

6 Job requirements

In this section we are gathering information about the plan member's specific physical job tasks. If you have a physical demands analysis, please provide it, **OR** complete the following section as applicable.

PHYSICAL DEMANDS OF JOB	Activity	Maximum weight (lbs.)	Frequency		
	Lifting		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Carrying		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Sitting		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Standing		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Walking		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant

7 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature	Title
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Telephone number ()	Date (dd/mmm/yyyy)
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The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.