Manulife

Employer Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of the plan member/employee's disability claim.

Please see page 2 for instructions.

Disability management

The most important thing you can do to facilitate your plan member/employee's safe and timely return to work is to maintain continuous contact with the plan member/employee from the time he/she leaves the workplace.

Be sure to let the plan member/employee know if your organization is able to provide transitional work duties and who the plan member/employee can talk to, confidentially, about their specific accommodation needs.

Employer instructions

- **Please print clearly; answer all applicable questions; sign and date the form.**
- Ensure the "Work information" section on page 7 is completed and signed by **plan member/ employee's supervisor**.
- Submit this form to the address below, **6 to 8 weeks prior to LTD eligibility date**, or as soon as it is known that the plan member/employee is not expected to return to work before the qualifying period has expired, even if the plan member/employee has applied, or been accepted for any type of workers' compensation benefits.
- Provide the plan member/employee with a Member/Employee Statement form and an Attending Physician's Statement form for the family physician or attending specialist. Ask the plan member/ employee to complete the "Patient authorization" section at the top of page 3 of the Attending Physician's Statement form before they take it to their physician.
- **Remind the plan member/employee to have their physician attach consultation, progress and test result reports to APS form (Attending Physician's Statement).**
- Help the plan member/employee understand the nature of the LTD coverage, what information is required and what costs, if any, are the plan member/employee's responsibility.
- Advise plan member/employee to submit forms to you **OR** Manulife **6 to 8 weeks prior to LTD eligibility date**, or as soon as it is known that the plan member/employee is not expected to return to work before the qualifying period has expired.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, the plan member/employee and the plan member/employee's physician(s) to compare restrictions and limitations with job demands.

All of the above information will be reviewed to determine whether the plan member/employee meets the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Employer checklist

- ◯ Employee's Statement
- ◯ Attending Physician's Statement
- ◯ Copies of reports from Specialists
- ◯ Copies of 444's
- ◯ Job description
- ◯ WCB correspondence
- ◯ Payment information - print screen of payroll details (including deductions)
- ◯ Completed Direct Deposit Form

Manulife Group Benefits
Attention: Disability Claims
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5
email: group_disability_claims@manulife.ca
Tel: 1-800-565-0627
Fax: 1-866-292-9050

www.manulife.ca/planmember

Manulife

Employer Statement
Long Term Disability Claim

Nova Scotia Public Service
Long Term Disability Trust Fund

Nova Scotia Public Service
Long Term Disability Plan Trust Fund

Halifax Group Disability Claim Office
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5

1 Employer

Plan number	Employer/Divsion		
84560			
Address (number, street and suite)		Province	Postal code
Contact	Title	Phone number	Fax number
		( ) Ext.	( )

2 Plan member/ employee identification

Name (last, first, initial)			
SIN	Union	Division number	Date of birth (dd/mmm/yyyy)
	◯ NSGEU ◯ CUPE ◯ Non-Union		

3 Life coverage

To be completed only if waiver of premium benefit involved. *Please provide copy of Enrolment Application.*

◯ **GROUP LIFE BENEFIT:**

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Annual salary $
Date of last increase (dd/mmm/yyyy)	Life coverage when last actively at work $

◯ Basic $	◯ Dependent spouse $
◯ Optional $	◯ Optional spousal $
◯ Dependent children $	

◯ **GROUP ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:**

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Amount of AD&D coverage $

◯ **GROUP SURVIVOR BENEFIT:**

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Monthly survivor benefit amount $

Type of coverage
◯ Spousal ◯ Spousal and children ◯ Other (specify)

4 LTD coverage information

a) What was the date of hire? (dd/mmm/yyyy)

b) On what date did LTD coverage become effective? (dd/mmm/yyyy)

c) How many years of pensionable service?

d) Has LTD coverage been terminated?

◯ Yes ◯ No *If yes, please show date coverage terminated, and explain why.*

Date coverage terminated (dd/mmm/yyyy)

Reason why LTD coverage terminated

e) What were the plan member/employee's work hours?

◯ Full-time ◯ Part-time ◯ Term ◯ Seasonal ◯ Relief ◯ Contract ◯ Other

HRS/WK _____

f) What was the employment status prior to the disability date?

◯ Actively employed *OR*

◯ Leave of absence ◯ Disability leave
◯ On layoff ◯ Pensioned
◯ Terminated

Please provide effective date (dd/mmm/yyyy)

5 Work schedule information

a) What was the date last worked and the next scheduled work date?

Date last worked (dd/mmm/yyyy)

Next scheduled work date (dd/mmm/yyyy)

b) List any dates plan member/employee worked during the qualifying period.

c) What is the return to work Return to work date?

Return to work date (dd/mmm/yyyy)

◯ Actual ◯ Expected ◯ Unknown

6 Plan member/ employee's earnings and benefit information

*Please provide the following information, **OR** a copy of the current payslip.*

a) What was the salary (for pension purposes) when the plan member was last at work?

Base salary/wage

$

Payment schedule

◯ Hourly ◯ Weekly ◯ Bi-weekly
◯ Semi-monthly ◯ Monthly ◯ Annual

b) Relief employee

Total salary paid in the 26 pay periods immediately preceding the pay period in which the disability occurred

c) What is the date of the last salary increase?

Date of last salary increase (dd/mmm/yyyy)

d) Please include payroll details print out with application.

Federal income tax

$

CPP/QPP contribution

$

Frequency

◯ Weekly ◯ Bi-weekly
◯ Monthly ◯ Semi-monthly
◯ Annual

Provincial income tax

$

EI (formerly UIC)

$

7 Tax information

*Please provide the following information, **OR** a completed TD1 or TP1.*

a) Net claim code for income tax purposes.

TD1

TP1

Member/employee's province of residence for income tax purposes

8 Additional earnings

a) Please indicate if any of the following have been paid (or are payable) since date plan member/employee last worked.

	PAID/PAYABLE	AMOUNT	PERIOD	
Salary continuance	◯ Yes ◯ No	$	To	From
Sick leave	◯ Yes ◯ No	$	To	From
Vacation pay	◯ Yes ◯ No	$	To	From
Short Term disability	◯ Yes ◯ No	$	To	From
Severance	◯ Yes ◯ No	$	To	From
Commission/Bonus	◯ Yes ◯ No	$	To	From
Retirement pension	◯ Yes ◯ No	$	To	From
Other	◯ Yes ◯ No	$	To	From

9 Workers' compensation information

a) Is the current disability due to a work related accident or illness? ◯ Yes ◯ No

If yes, has a claim been filed with the appropriate board? ◯ Yes ◯ No

b) Please provide a copy of the Accident/Illness report and:

Workers' compensation board contact name	Phone number	Fax number
	( ) Ext.	( )

Claim number	Date benefit commenced (dd/mmm/yyyy)	Date benefit ceased (dd/mmm/yyyy)

c) What is/was the benefit amount?

Benefit amount			
$	◯ Weekly	◯ Bi-weekly	◯ Monthly

d) Is the plan member/employee receiving any other type of workers' compensation income? ◯ Yes ◯ No

Permanent award	Effective date (dd/mmm/yyyy)
$	
Workers' compensation board supplements	**Effective date (dd/mmm/yyyy)**
$	
Lump sum settlement	**Payment period**
$	

10 Disability management contact

What is the name, job title and phone number of the person responsible for disability management involved in disability absences? ◯ N/A

Name	Job title	Phone number
		( ) Ext.

Return to work contact

What is the name, job title and phone number of the person in your organization we should contact to facilitate a return to work once this plan member/employee's abilities and limitations are known?

Name	Job title	Phone number
		( ) Ext.

11 Other information

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

Please attach any medical or other information provided to or obtained by you, relative to the plan member/employee's absence.

12 Declaration

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

Employer/Human Resources Representative's signature	Title

Employer/Human Resources Representative's phone number	Date (dd/mmm/yyyy)

The information in this statement will become part of a Group Life and Health Benefits file which might be accessible by the plan member/employee or third parties to whom access has been granted or those authorized by law.

Note: Please see next page and ensure the remainder of this form is completed.

Please ensure that the remainder of this form is completed by the plan member/employee's supervisor.

Sections 13 - 17 may be separated from the rest of the form, if required.

A separate fillable file is available for the supervisor section.

13 Plan member/employee identification

Please provide this information again if you plan to separate sections 13 to 17 for the plan member/employee's supervisor to complete.

Plan contract number
84560

Name (last, first, initial)

Class

Division number

14 Work information

THIS SECTION TO BE COMPLETED BY THE PLAN MEMBER/EMPLOYEE'S IMMEDIATE SUPERVISOR. Please enclose a detailed job description for the plan member/employee. The description must be for the job the plan member/employee was performing immediately prior to the date last worked.

a) What was the plan member/employee's job title as of the last day worked?

Job title

b) How long has the plan member/employee held this position?

Position held
years months

c) How long is the plan member/employee's usual work day?

Length of plan member/employee's work day

d) What is the usual work pattern? (i.e. number of shifts worked per week)

Plan member/employee's usual work pattern

e) What are the primary duties of the plan member/employee's job? (e.g. operate machinery, do research/analysis, handle shipping/receiving, do sales activities, has management/supervising responsibilities, perform customer service duties, maintain electrical/mechanical equipment, use a computer, etc.)

PRIMARY DUTIES	TIMES	**OR**	HOURS PER DAY

15 Job requirements

Before the plan member/employee stopped working, did the illness or injury cause them to change:

		Date (dd/mmm/yyyy)	Explanation
Job duties	◯ Yes ◯ No		
Job performance	◯ Yes ◯ No		
Equipment	◯ Yes ◯ No		
Environment	◯ Yes ◯ No		
Hours of work	◯ Yes ◯ No		
Attendance	◯ Yes ◯ No		

16 Other information

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

17 Declaration

Print

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

Authorized signature	Title

Telephone	Date (dd/mmm/yyyy)

The information in this statement will become part of a Group Life and Health Benefits file which might be accessible by the plan member/employee or third parties to whom access has been granted or those authorized by law.