MANITOBA BLUE CROSS®

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# APPLICATION FOR BENEFITS
# Employer's Statement

**To be completed by the Plan Administrator.**
**Submit directly to Manitoba Blue Cross, Case Management Services. See contact information above.**
***It is the responsibility of the insured member to submit the Employee's Statement and Attending Physician's Statement.***

| Policy Name | Select applicable plan(s) |
|---|---|
| Policy ID (5 digit number) Policy Division (3 digit number) | ☐ Weekly Indemnity (Short Term Disability)<br>☐ Long Term Disability<br>☐ Waiver of Premium |

## Employee (Member) Identification

| Last Name | First Name | Middle Name or Initial |
|---|---|---|
| | | |

| Certificate Number | Coverage Classification (e.g. Class A) | Social Insurance Number |
|---|---|---|
| | | |

Birth Date (yyyy-mm-dd) _____ Gender ☐ Male ☐ Female

Employee's Address (Street, City, Province, Postal Code)

| Primary Phone Number (include area code) | Alternate Phone Number (include area code) |
|---|---|
| ☐ Home ☐ Cell | ☐ Home ☐ Cell |

## Position Identification *(attach the current job description, summary of duties or Job Analysis Form)*

Position/Job Title (as of last day worked)

Employment start/hire date (yyyy-mm-dd) _____

Canada Revenue Agency TD1 claim code

Start date of the current Position/Job Title, if different from above (yyyy-mm-dd) _____

Effective date of coverage (yyyy-mm-dd) _____

Basic regular gross earnings (pre-disability)
$ _____ ☐ Hourly ☐ Weekly ☐ Monthly

Last Day Worked (yyyy-mm-dd) _____

Regular Work Schedule

Usual number of hours worked each week _____

Usual scheduled work days each week

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday
☐ Friday ☐ Saturday ☐ Sunday

Usual scheduled work hours each shift

_____ a.m. / p.m. to _____ a.m. / p.m.

**If this position requires a varied schedule or rotational shift work, please provide details in the General Remarks found on page 2.*

Return To Work (RTW)

Confirmed RTW Date (yyyy-mm-dd) _____ or Expected RTW Date (yyyy-mm-dd) _____

Capacity of RTW ☐ Full-time ☐ Part-time _____

☐ Regular work ☐ Modified Duties _____

If deemed medically supported and/or appropriate by Manitoba Blue Cross, will you accommodate a return to work plan?

☐ Yes ☐ No, explanation _____

Is the employee's job being held for him/her?

☐ Yes ☐ No, explanation _____

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## Other Sources of Income *(since the last day worked)*

| | | |
|---|---|---|
| ☐ Salary Continuation | From (yyyy-mm-dd) _____ | To (yyyy-mm-dd) _____ |
| ☐ Paid Sick Leave | From (yyyy-mm-dd) _____ | To (yyyy-mm-dd) _____ |
| ☐ Paid Vacation | From (yyyy-mm-dd) _____ | To (yyyy-mm-dd) _____ |
| ☐ Other _____ | From (yyyy-mm-dd) _____ | To (yyyy-mm-dd) _____ |

## Disability Information *(attach all medical certificates/notes received in relation to this absence)*

Has the employee been provided with full details of benefits under this plan? ☐ Yes ☐ No

Is this condition due, or related, to occupational illness or accident (past or present)? ☐ Yes ☐ No

If yes, state how it occurred _____

Has the employee applied for any other benefits, such as Workers Compensation Board, automobile insurance, employment insurance, private or public pension, etc.? ☐ Yes, Carrier _____ ☐ No

If yes, indicate the date of application, claim/file number, decision and claim/file status. *(attach applicable correspondence)*

Has the employee previously submitted an application for life and/or disability benefits? ☐ Yes ☐ No

If yes, include dates paid and insurance carrier From (yyyy-mm-dd) _____ To (yyyy-mm-dd) _____

☐ Manitoba Blue Cross ☐ Other Carrier _____

## General Remarks

Provide any additional information which may be of value in consideration of this claim. (e.g. accommodation prior to leave of absence, job performance, attendance pattern, workplace issues or conflict, etc.)

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

Name (please print)

| | |
|---|---|
| Position/Title | ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. |
| Phone Number (include area code) | Fax Number (include area code) |
| Mailing Address | Email Address |
| Signature | Date (yyyy-mm-dd) |