MANITOBA BLUE CROSS®

Case Management Services

APPLICATION FOR BENEFITS
Employer's Statement

Notice

To be completed by the Plan Administrator. We accept submission by

Email LDinfo@mb.bluecross.ca
Fax 204.788.5591

*It is the responsibility of the insured member to submit the Employee's Statement and Attending Physician's Statement.

This application is for (please select)

- ☐ Weekly Indemnity (Short Term Disability)
- ☐ Long Term Disability
- ☐ Waiver of Premium

Policy Name

Policy Number

Employee (Member)

Last Name | First Name | Middle Name

Certificate Number | Coverage Classification (e.g. Class A) | Employer Name (if different from Policy Name)

Birth Date (yyyy-mm-dd) | Social Insurance Number

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

Primary Phone Number (include area code)
☐ Home ☐ Cell

Alternate Phone Number (include area code)
☐ Home ☐ Cell

Employment

Position/Job Title (as of last day worked)

***attach the current job description, summary of duties or Job Analysis Form**

Basic regular gross earnings (pre-disability)

$_____ ☐ Hourly ☐ Weekly ☐ Monthly

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

Canada Revenue Agency TD1 claim code

Start date of coverage Position/Job Title (if different from above) (yyyy-mm-dd)

Effective date of coverage (yyyy-mm-dd)

Attendance Pattern
Number of days absent from duty due to illness
in the past 12 months _____
average days absent in previous year _____

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?

☐ Yes ☐ No, explanation _____

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, 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)	Posititon/Title
Phone Number (include area code)	Fax Number (include area code)
Mailing Address (Street, City, Province, Postal Code)	
Email Address	
Signature	Date (yyyy-mm-dd)