

Employer Statement Application for Benefits

CHECK ONE OR BOTH:

- LONG TERM DISABILITY (LTD) BENEFITS**
 CONTINUATION OF BENEFITS DURING DISABILITY (WAIVER OF PREMIUM)

COMPLETE AND RETURN TO:

Vestcor	Telephone: (506) 453-2296
P.O. Box 6000	Toll Free in Canada: 1-800-561-4012
Fredericton, NB E3B 5H1	Fax: (506) 457-7388

General Information

Employee's First Name _____ Employee's Last Name _____ SIN _____ Date of Birth (D/M/Y) _____

Address _____

Telephone Number - at home (____) _____ - _____ at work (____) _____ - _____

Date employee last worked—immediately before disability started (DD/MM/YYYY) ____/____/____

Position and Salary

Employment Start Date(DD/MM/YYYY) ____/____/____ Bargaining Group/Unit _____

Occupation/Position _____ **REMINDER! ATTACH JOB DESCRIPTION**

Position Status full-time/regular part-time/regular other, describe: _____

Does the employee participate in Phased Retirement Work Time Flexibility (5 years pre-retirement) N/A

Hours worked in a week (weekly average if shift work) _____ Income Tax Code as per current TD1 Form _____

Other Disability Benefits/Income

Has the employee requested/received employer-paid leave as income continuance beyond the last day worked/started of disability?
 Yes No If yes, how many sick days? _____ and/or vacation days? _____

If yes, indicate date ending period of paid leave as understood with employee (DD/MM/YYYY) ____/____/____

IMPORTANT! The date above must be completed. If date changes, a note or email must be sent to Vestcor.

Is employee's condition due, or related, to occupational illness or accident (past or present)? Yes No

Has a claim been filed under the *Workers' Compensation Act*? Yes - see A and B below No

A) If yes, are benefits payable? Yes Decision Pending No

B) If yes, amount \$ _____ paid bi-weekly monthly;
 from (DD/MM/YYYY) ____/____/____ to (DD/MM/YYYY) ____/____/____

If applicable, indicate dates and number of hours (for each day) employee worked during the 4-month qualifying period (from date last worked indicated in "General Information"):

Describe any efforts made to accommodate employee (e.g. transitional work duties/work schedules, special equipment, etc.):

Claim Admissibility

Date employee's LTD coverage started (DD/MM/YYYY) _____ / _____ / _____

Latest monthly premiums/contributions paid for employee's coverages (MM/YYYY) _____ / _____

NOTE: Latest monthly premiums/contributions, with respect to requested benefits, must be paid for the 4-month qualifying period from date of disability. Note: Employee benefit premiums/contributions must continue while employee on paid leave.

If employee has Health and/or Dental coverage, please complete the following:

Policy # _____ Identification # _____ Premiums paid to (MM/YYYY) _____ / _____

Employer Information

Name of Employer Organization _____

Representative's Name _____

Telephone Number (_____) _____ - _____ E-mail Address _____

Representative's Signature _____ Date _____

For Vestcor Use Only

LONG TERM DISABILITY

Plan/Policy Number 6666 Division _____ PIBA Bargaining Unit Code _____

Employee's date of A) eligibility/enrolment in LTD Plan ____ / ____ / ____ B) Hire with Province of NB ____ / ____ / ____
DD MM YYYY DD MM YYYY

Date above corresponds with (check all that apply)

- Start of employment
- Change in employment status
- Plan implementation for employee's group
- Approval Late Application for LTD Coverage

LTD Coverage continued during qualifying period? Yes No

Gross Monthly Salary \$ _____ Monthly LTD Benefit \$ _____ Maximum Benefit Period _____

WAIVER OF PREMIUM

Life Policy Number 19800-000 Division: Employee Excess Supplementary (Judges only)

Coverage continued during qualifying period? Basic Life Yes No Optional Life Yes No Dependent Life Yes No

Life coverage \$ _____ Optional Coverage \$ _____

AUTHORIZED BY _____ DATE _____