

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 _____ Date of Birth (D/M/Y) _____
Address _____
Telephone Number - at home (____)____-____ at work (____)____-____
Date employee last worked—immediately before disability started (D/M/Y) ____/____/____

Position and Salary

Employment Start Date(D/M/Y) ____/____/____ 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 (D/M/Y) ____/____/____

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 (D/M/Y) ____/____/____ to (D/M/Y) ____/____/____

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 (D/M/Y) _____ / _____ / _____

Latest monthly premiums paid for employee's coverages (M/Y) _____ / _____

NOTE: Latest monthly premiums, with respect to requested benefits, must be paid for the 4-monthly 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 # _____

Type of Coverage: Employee-Only (Single) Employee + a Dependent (Two-Person) Employee + 2 or More Dependents No Coverage

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

Reference # _____ Plan/Policy Number 6666 Division _____ Bargaining Unit _____

Employee's date of (D/M/Y) A) eligibility/enrolment in LTD Plan ____/____/____ B) Hire with Province of NB ____/____/____

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 Pending Life coverage \$ _____
Optional Life Yes No Pending Optional Coverage \$ _____
Dependent Life Yes No Pending

AUTHORIZED BY _____ DATE _____