New Nouveau Brunswick

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
P.O. Box 6000
Fredericton, NB E3B 5H1

Telephone: (506) 453-2296
Toll Free in Canada: 1-800-561-4012
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 (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-monthy 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 (M/Y) _______ /_____________

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
	Optional Life	☐ Yes	☐ No	☐ Pending
	Dependent Life	☐ Yes	☐ No	☐ Pending

Life coverage $________________________

Optional Coverage $_____________________

AUTHORIZED BY ____ DATE ____________________________