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) _____ /_____

Type of Coverage: ☐ Employee-Only (Single) ☐ Employee + 1 Dependent (Two-Person) ☐ Employee + 2 or More Dependents

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 _____