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

➡ ***Please print.***

A. General Information:

1) Name of Employee _____
(First) (Last)

2) SIN: ____ ____ ____ - ____ ____ ____ - ____ ____ ____

3) Date of Birth D M Y

4) Address: _____

_____

5) Telephone Number - at home: ( ) _____ - _____ ; at work: ( ) _____ - _____

6) Date employee last worked – immediately before disability started: D M Y

B. Position & Salary:

7) Employment Start Date: D M Y

8) Bargaining Group/Unit: _____

9) Occupation/Position: _____ ➡ ***Attach job description***.

10) Position Status: ☐ full-time/regular; ☐ part-time/regular; ☐ other, describe: _____

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

12) Hours worked in a week (weekly average if shift work): _____

13) Income Tax Code as per current TD1 form: _____

C. Other Disability Benefits/Income:

14) Has employee requested/received employer-paid leave as income continuance beyond the last day worked/start 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 ➡ **This date must be completed. If date changes, a note or email must be sent to Vestcor.**

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

16) Has a claim been filed under the Workers' Compensation Act? ☐ Yes - see a & b ☐ 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

(continued on reverse)

17) If applicable, indicate dates and number of hours (for each day) employee worked during the 4-month qualifying period (from date indicated in No. 6 above):_____

_____

_____

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

_____

_____

D. Claim Admissibility:

19) Date employee's LTD coverage started: D M Y

20) Latest monthly premiums/contributions paid for employee's coverages: _____ (month/year)

➡ 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.

21) If employee has Health and/or Dental coverage (Blue Cross), please complete the following:

Policy # _____ Identification # _____Premiums paid to: _____(month/year)

E. Employer Information:

22) Name of Employer Organization: _____

23) Representative's Name: _____

24) Tel.: ( ) _____ - _____ e-mail address: _____

25) Representative's Signature: _____ Date: _____

F. FOR VESTCOR USE

1) Employee's date of: a) eligibility/enrolment in LTD Plan: D M Y b) hire with Province of NB: D M Y

2) 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 ☐

3) Coverage continued/to continue during qualifying period? Yes ☐ No ☐

4) Plan/Policy Number _____ 5) Division _____

6) PIBA Bargaining Unit Code: _____ 7) Gross Monthly Salary: $ _____

8) Monthly LTD Benefit: $ _____ 9) Maximum Benefit Period: _____

For Waiver of Premium Only: Life Coverage: $ _____ Supplementary Life: $ _____ Dependent Life (Y/N) _____

Authorized by _____ Date _____