New Nouveau Brunswick

**EMPLOYEE STATEMENT – APPLICATION FOR BENEFITS**

☐ **LONG TERM DISABILITY (LTD) BENEFITS**

☐ **CONTINUATION OF COVERAGE DURING DISABILITY (WAIVER OF PREMIUM)**

Complete and return to:

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

1. EMPLOYEE INFORMATION (Please Print)

Name (first/last) _____

Sex: ☐ male ☐ female Date of Birth D M Y ➡ **Attach copy of birth certificate.** SIN

Employer (name department, agency, hospital, school district or other) _____ Latest Occupation _____

2. APPLICATION FOR BENEFITS INFORMATION - Please identify which benefits you are claiming.

a) ☐ Long Term Disability (LTD) Benefits

b) ☐ Continuation of coverage while disabled - please indicate which plans apply:

- ☐ Accidental Death & Dismemberment Insurance
- ☐ Long Term Disability Plan
- ☐ Basic Life Insurance
- ☐ Supplementary Life Insurance
- ☐ Dependant Life Insurance
- ☐ Health and/or Dental Plans ➡ Policy # _____ Identification # _____
  (Located on your Medavie Blue Cross ID card)

c) ☐ Disability Pension (under Teacher's Pension Plan only)

3. INCOME/BENEFIT INFORMATION

Are you receiving salary continuation (paid sick leave, vacation) from your employer? ☐ Yes ☐ No If yes, to what date? (d/m/y) _____

Have you applied for Disability Benefits from the Canada Pension Plan or the Quebec Pension Plan? ☐ Yes ☐ No

Is this claim the result of a work related injury/illness - past or present? ☐ Yes ☐ No

Has a claim been filed under the Worker's Compensation Act? ☐ Yes ☐ No If yes, are benefits payable? ☐ Yes ☐ No ☐ Decision Pending

Is this claim the result of a motor vehicle accident? ☐ Yes ☐ No If yes, is there any legal action involved? ☐ Yes ☐ No

If yes, please provide lawyer's name and address: _____

Are you claiming or receiving salary replacement disability benefits from another group insurance, association or franchise plan? ☐ Yes ☐ No

If yes, name of insurance company: _____ Policy Number: _____

4. MEDICAL CONDITION AND WORK INFORMATION

When did symptoms begin that developed into your present medical condition? _____

From what date has your condition prevented you from working? (d/m/y) _____

Describe your present medical condition, its cause and history. (If you were injured as a result of an accident, describe what happened, when and where it took place.)

Which of your regular job functions could you still fulfill? _____

Which of your regular job functions could you not fulfill? _____

Have you attempted to return to work? ☐ Yes ☐ No If yes check where applicable: ☐ full-time ☐ part-time ☐ regular duties ☐ modified duties ☐ other employer

If no, when do you expect to return to - your regular occupation? (d/m/y) _____ - any other occupation? (d/m/y) _____

Have you previously claimed long-term disability or continuation of coverage benefits under benefit plans for Employees of the Province of N.B.? ☐ Yes ☐ No

Have you had a similar injury or illness in the past? ☐ Yes ☐ No If yes, describe, including original date and if any leave was taken from work: _____

Please provide any additional information that you believe should be considered in assessing your claim. (Attach additional sheets if needed.) _____

5. MEDICAL INFORMATION

**To reduce delays in the assessment of your claim, attach all available test results, consultation reports and hospital discharge summaries - in addition to the Attending Physician Statement.**

List all Physicians (including any other specialist or health care practitioner) that you have seen for your present medical condition.

| Name of Physician/Specialist | Type of Practitioner | Address | Date of 1st visit | Date of next visit | Date(s)of Hospitalization |
|---|---|---|---|---|---|
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6. EDUCATION, TRAINING AND EXPERIENCE INFORMATION (Attach copy of current resume or complete information where applicable.)

Highest grade level of education completed _____ Technical/Trade School _____ Type of Diploma obtained _____

College/ University _____ Years completed _____ Type of Diploma obtained _____ Year _____ Major _____

Briefly describe types of employment held in last 15 years: _____

List any technical, administrative or special interest courses taken: _____

List skills acquired in current and previous positions:
(E.g. typing, operation of equipment, supervisory skills, special licenses or designations) _____

7. If applicable, I hereby authorize release of my name to my union as a Long Term Disability claimant.

Signature of Employee: _____ Date: _____

8. ASSIGNMENT, CERTIFICATION AND AUTHORIZATION **(SIGNATURE REQUIRED)**

I certify that the information in this form is true and complete. I understand the Claims Administrator may investigate this claim. I authorize my employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medically-related facility, insurance company, Worker's Compensation authority, Canada or Quebec Pension Plan, group plan administrator, employer-sponsored pension plan administrator, to release and exchange with the Claims Administrator and the Plan Administrator any medical or benefit payment information to process or manage my claim. I agree that a photocopy of this authorization shall be as valid as the original. I understand that any charges for having forms completed or medical reports are my responsibility.

Signature of Employee: _____ Date: _____

Address and Postal Code: _____

_____ Tel. No:_____