# Employer Statement - Application for Benefits For Nurses Employed in Nursing Homes

**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 | 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.

## Employer Information

Name of Employer Organization _____

Representative's Name _____

Telephone Number ( _____ ) _____ - _____ Email 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 _____

AUTHORIZED BY _____ DATE _____