LONG-TERM DISABILITY
PLAN SPONSOR STATEMENT

Please return this completed form and supporting documents to:

Wawanesa Life - Claims
236 Carlton St, Winnipeg, MB R3C 1P5
For inquiries, please call: 1-844-318-0411, #4
Fax 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

PLAN SPONSOR IDENTIFICATION

Group Plan #_____ Account #_____

Plan Sponsor _____

Address _____
Street City Province Postal Code

Phone Number _____ Email _____ Fax :_____

PLAN MEMBER IDENTIFICATION

Plan Member_____ Plan Member ID _____
Last Name First Name Initial

EARNINGS INFORMATION if WCB/WSIB/CSST claim, attach initial report of illness or injury and award notice

Plan Member's salary as of last day worked _____ ☐ Hourly ☐ Monthly ☐ Annually

Effective date of salary _____
(yy/mm/dd)

Has a claim been filed with another wage loss provider? ☐ Yes ☐ No

If 'Yes", select provider ☐ WCB/WSIB/CSST ☐ CPP/QPP ☐ Auto ☐ Other, specify _____

Date _____ Decision _____ Amount _____
(yy/mm/dd)

EMPLOYMENT INFORMATION

Effective date of insurance _____ Date of hire _____
(yy/mm/dd) (yy/mm/dd)

Last day worked _____ Hours worked _____
(yy/mm/dd)

Salary or sick leave benefits paid to:_____ If laid off or on leave, date of commencement _____ and recall_____
(yy/mm/dd) (yy/mm/dd) (yy/mm/dd)

Employee Classification: ☐ Full Time: Hours per week _____ ☐ Part Time: Hours per week _____

Please explain the Plan Member's typical work week (eg. Monday to Friday, 8 am to 5 pm) _____

Reason for absence: ☐ Medical ☐ Leave of absence ☐ Dismissed ☐ Temporary lay-off

☐ Quit ☐ Work related accident or sickness ☐ Strike

☐ Retired ☐ Other _____

Has the Plan Member returned to work? ☐ Yes ☐ No If 'Yes', please indicate date _____ If 'No', is return to work date known _____
(yy/mm/dd) (yy/mm/dd)

JOB INFORMATION

Plan Member's position/title _____

Effective date of position _____
(yy/mm/dd)

What department does the Plan Member work in? _____

What are the essential duties of this job and what percentage of time do they involve?

Duties	Percentage (%)

For questions A, B, and C, frequency is defined as follows: Occasionally: 1-20%; Frequently: 21-50%; Always: 51+ %; N/A: Not Applicable

A. **Work environment** – Does the involve:

Frequency	O	F	A	N/A
Outside	☐	☐	☐	☐
Extreme cold or heat	☐	☐	☐	☐
Toxic fumes	☐	☐	☐	☐

	O	F	A	N/A
Damp or humid environment	☐	☐	☐	☐
Above or below ground	☐	☐	☐	☐
Handling chemicals	☐	☐	☐	☐

B. **Mobility** – Does the job involve:

Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐

Bending or crouching	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐

C. **Strength** – Does the job require the Plan Member to carry more than:

50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐
	☐	☐	☐	☐

Does the job require the Plan Member to lift more than:

50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐
	☐	☐	☐	☐

Indicate any equipment used by the Plan Member (eg. Computer, drill, etc.)

Type	Percentage (%) of day

Please check the time frame that most accurately reflects the amount of time the Plan Member is required to maintain the following activities before changing position or activity.

	At one time (minutes)				Per day (hours)			
	0-30	30-60	60-90	>90	0-2	2-4	4-6	6-8
Sitting	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐

How much of the Plan Member's time is spent:

Talking _____ %

Writing _____ %

Supervising other people _____ %

Were any modifications made in the Plan Member's job duties as a result of the condition? ☐ Yes ☐ No

If 'Yes', please explain and give the effective date.

_____

_____

ADDITIONAL INFORMATION

Should it be medically supported that the Plan Member return to work on a rehabilitative basis, can such an endeavor be accommodated (eg. Gradual return to work, modified work duties, temporary basis, permanent part-time basis, temporary alternate position, permanent alternate position, etc.)

Prior to the Plan Member's return to work, are there any employment issues that need to be addressed. If yes, please explain.

Please confirm the Plan Member's current employee status, if terminated, please indicate date of termination.

Please provide any additional information that you believe should be considered in assessing this claim.

PERSONAL INFORMATION CONSENT :

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued, or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

I certify that to the best of my knowledge, the above statements are true and correct.

Name

Title

(yy/mm/dd)

Authorized Signature