



Employer Statement

- Long Term Disability Claim
- Waiver of Premium Claim for:
 - Basic & Optional Life Benefit
 - AD&D Benefit
 - Survivor Benefit

An incomplete form may result in delays in the adjudication of the plan member/employee's disability claim.

Please see page 2 for instructions.

Disability management

The most important thing you can do to facilitate your plan member/employee's safe and timely return to work is to maintain continuous contact with the plan member/employee from the time he/she leaves the workplace.

Be sure to let the plan member/employee know if your organization is able to provide transitional work duties and who the plan member/employee can talk to, confidentially, about his or her specific accommodation needs.

Employer instructions

- **Please print clearly; answer all applicable questions; sign and date the form.**
- Ensure the "Work information" section on page 7 is completed and signed by **plan member/employee's supervisor**.
- Submit this form to the address below, **6 to 8 weeks prior to LTD eligibility date**, or as soon as it is known that the plan member/employee is not expected to return to work before the qualifying period has expired, even if the plan member/employee has applied, or been accepted for any type of workers' compensation benefits.
- Provide the plan member/employee with a Member/Employee Statement form and an Attending Physician's Statement form for the family physician or attending specialist. Ask the plan member/employee to complete the "Patient authorization" section at the top of page 3 of the Attending Physician's Statement form before they take it to their physician.
- **Remind the plan member/employee to have their physician attach consultation, progress and test result reports to APS form (Attending Physician's Statement).**
- Help the plan member/employee understand the nature of the LTD coverage, what information is required and what costs, if any, are the plan member/employee's responsibility.
- Advise plan member/employee to submit forms to you **OR Manulife 6 to 8 weeks prior to LTD eligibility date**, or as soon as it is known that the plan member/employee is not expected to return to work before the qualifying period has expired.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, the plan member/employee and the plan member/employee's physician(s) to compare restrictions and limitations with job demands.

All of the above information will be reviewed to determine whether the plan member/employee meets the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Employer checklist

- Employee's Statement
- Attending Physician's Statement
- Copies of reports from Specialists
- Copies of 444's
- Job description
- WCB correspondence
- Payment information - print screen of payroll details (including deductions)
- Completed Direct Deposit Form

Manulife Financial Group Benefits

Attention: Disability Claims
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5
Tel: 1-800-565-0627
(902) 453-4300
Fax: (902) 429-7292

www.manulife.ca/groupbenefits

Halifax Group Disability Claim Office
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5

**Nova Scotia Public Service
Long Term Disability Trust Fund**

1 Employer

Plan number 84560	Employer/Division		
Address		Province	Postal code
Contact	Title	Phone number	Fax number

2 Plan member/employee identification

Name (last, first, initial)		<input type="radio"/> Mr.	<input type="radio"/> Ms.
		<input type="radio"/> Miss	<input type="radio"/> Mrs.
SIN	Union <input type="radio"/> NSGEU <input type="radio"/> CUPE <input type="radio"/> Non-Union	Division number	Date of birth (dd/mmm/yyyy)

3 Life coverage

To be completed only if waiver of premium benefit involved. *Please provide copy of Enrolment Application.*

GROUP LIFE BENEFIT:

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Annual salary \$
Date of last increase (dd/mmm/yyyy)	Life coverage when last actively at work \$
<input type="radio"/> Basic \$	<input type="radio"/> Dependent spouse \$
<input type="radio"/> Optional \$	<input type="radio"/> Optional spousal \$
<input type="radio"/> Dependent children \$	

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Amount of AD&D coverage \$

GROUP SURVIVOR BENEFIT:

Plan/Group number	Division number
Effective date of coverage (dd/mmm/yyyy)	Monthly survivor benefit amount \$
Type of coverage <input type="radio"/> Spousal <input type="radio"/> Spousal and children <input type="radio"/> Other (specify)	

4 LTD coverage information

- a) What was the date of hire?
- b) On what date did LTD coverage become effective?
- c) How many years of pensionable service?

(dd/mmm/yyyy)
(dd/mmm/yyyy)

d) Has LTD coverage been terminated?

Yes No *If yes, please show date coverage terminated, and explain why.*

Date coverage terminated (dd/mmm/yyyy)	Reason why LTD coverage terminated
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e) What were the plan member/employee's work hours?

Full-time Part-time Term Seasonal Relief Contract Other
HRS/WK _____

f) What was the employment status prior to the disability date?

Actively employed **OR** Leave of absence Disability leave On layoff Pensioned Terminated
Please provide effective date (dd/mmm/yyyy)

5 Work schedule information

a) What was the date last worked and the next scheduled work date?

Date last worked (dd/mmm/yyyy)	Next scheduled work date (dd/mmm/yyyy)
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b) List any dates plan member/employee worked during the qualifying period.

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c) What is the return to work date?

Return to work date (dd/mmm/yyyy)	<input type="radio"/> Actual <input type="radio"/> Expected <input type="radio"/> Unknown
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6 Plan member/employee's earnings and benefit information

a) What was the base salary/wage as of the last day of the elimination period (other than relief workers)?

*Please provide the following information, **OR** a copy of the current payslip.*

Base salary/wage \$	Payment schedule <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Bi-weekly <input type="radio"/> Semi-monthly <input type="radio"/> Monthly <input type="radio"/> Annual
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b) Relief employee

Total salary paid in the 26 pay periods immediately preceding the pay period in which the disability occurred \$

c) What is the date of the last salary increase?

Date of last salary increase (dd/mmm/yyyy)
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d) Please include payroll details print out with application.

Federal income tax \$	CPP/QPP contribution \$	Frequency <input type="radio"/> Weekly <input type="radio"/> Bi-weekly
Provincial income tax \$	EI (formerly UIC) \$	<input type="radio"/> Monthly <input type="radio"/> Semi-monthly <input type="radio"/> Annual

7 Tax information

a) Net claim code for income tax purposes.

*Please provide the following information, **OR** a completed TD1 or TP1.*

TD1	TP1	Member/employee's province of residence for income tax purposes
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8 Additional earnings

a) Please indicate if any of the following have been paid (or are payable) since date plan member/employee last worked.

	PAID/PAYABLE	AMOUNT	PERIOD	
Salary continuance	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Sick leave	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Vacation pay	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Short Term disability	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Severance	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Commission/Bonus	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Retirement pension	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From
Other	<input type="radio"/> Yes <input type="radio"/> No	\$	To	From

9 Workers' compensation information

a) Is the current disability due to a work related accident or illness?

Yes No *If yes, has a claim been filed with the appropriate board?* Yes No

b) Please provide a copy of the Accident/Illness report and:

Workers' compensation board contact name	Phone number	Fax number
Claim number	Date benefit commenced (dd/mmm/yyyy)	Date benefit ceased (dd/mmm/yyyy)

c) What is/was the benefit amount?

Benefit amount \$ Weekly Bi-weekly Monthly

d) Is the plan member/employee receiving any other type of workers' compensation income?

<input type="radio"/> Yes <input type="radio"/> No	Permanent award \$	Effective date (dd/mmm/yyyy)
	Workers' compensation board supplements \$	Effective date (dd/mmm/yyyy)
	Lump sum settlement \$	Payment period

10 Disability management contact

What is the name, job title and phone number of the person responsible for disability management involved in disability absences? N/A

Name	Job title	Phone number
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Return to work contact

What is the name, job title and phone number of the person in your organization we should contact to facilitate a return to work once this plan member/employee's abilities and limitations are known?

Name	Job title	Phone number
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11 Other information

Please provide any additional information that you believe should be considered in assessing this plan member/employee's claim.

Please attach any medical or other information provided to or obtained by you, relative to the plan member/employee's absence.

12 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Employer/Human Resources Representative's signature	Title
Employer/Human Resources Representative's phone number ()	Date (dd/mmm/yyyy)

The information in this statement will become part of a Group Life and Health Benefits file which might be accessible by the plan member/employee or third parties to whom access has been granted or those authorized by law.

Note: Please see next page and ensure the remainder of this form is completed.

**Please ensure that the remainder
of this form is completed by the
plan member/employee's supervisor.**

**Sections 13 - 17 may be separated
from the rest of the form, if required.**

**A separate fillable file is available
for the supervisor section.**

13 Plan member/employee identification

Please provide this information again if you plan to separate sections 13 to 17 for the plan member/employee's supervisor to complete.

Plan number
84560

Name (last, first, initial) Mr. Ms.
 Miss Mrs.

Class Division number

14 Work information

THIS SECTION TO BE COMPLETED BY THE PLAN MEMBER/EMPLOYEE'S IMMEDIATE SUPERVISOR. Please enclose a detailed job description for the plan member/employee. The description must be for the job the plan member/employee was performing immediately prior to the date last worked.

a) What was the plan member/employee's job title as of the last day worked?

Job title

b) How long has the plan member/employee held this position?

Position held _____ years _____ months

c) How long is the plan member/employee's usual work day?

Length of plan member/employee's work day

d) What is the usual work pattern? (i.e. number of shifts worked per week)

Plan member/employee's usual work pattern

e) What are the primary duties of the plan member/employee's job? (e.g. operate machinery, do research/analysis, handle shipping/receiving, do sales activities, has management/supervising responsibilities, perform customer service duties, maintain electrical/mechanical equipment, use a computer, etc.)

PRIMARY DUTIES	TIMES	OR	HOURS PER DAY

f) Please list any office machines, tools or other equipment that the plan member/employee uses in this job.

TYPE OF EQUIPMENT	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15 Job requirements

a) In this section we are gathering information about the plan member/employee's specific physical or psychological job tasks. If you have a physical or psychological demands analysis, please provide it, **OR** complete the following section as applicable.

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kneeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending/Squatting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crouching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crawling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation; fingers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Simple grasping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine manipulation; hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repetitive body motions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - at shoulder level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - below shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - side to side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching - up and down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PHYSICAL DEMANDS OF JOB

Lifting / Carrying	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY		
Lifting - floor to waist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Lifting - waist to shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Lifting - above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
Carrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant

Are assistive devices utilized available N/A

Is your plan member/employee required to work in any of the following conditions?	Yes	No
Exposure to marked changes in temperatures and humidity	<input type="radio"/>	<input type="radio"/>
Being around moving machinery	<input type="radio"/>	<input type="radio"/>
Unprotected heights	<input type="radio"/>	<input type="radio"/>
Exposure to dust, fumes and gases	<input type="radio"/>	<input type="radio"/>
Driving automobile equipment	<input type="radio"/>	<input type="radio"/>
Is the plan member/employee able to change position as comfort requires?	<input type="radio"/>	<input type="radio"/>

Which of the following categories best describes the psychological demands of your plan member/employee's job?

PSYCHOLOGICAL DEMANDS OF JOB	A. Understanding and memory	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
	Remember locations and routine procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Understand and remember detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	B. Sustained concentration and persistence	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
	Carry out short and simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Carry out detailed instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Maintain attention and concentration for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Perform activities within a schedule	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Sustain an ordinary routine without supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make simple decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Solve simple straightforward problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Solve complex problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
C. Social interaction	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	
Interact with the general public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Ask questions or request assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Accept instructions and feedback	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Get along well with others without distracting them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Get along well with others without being distracted by them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
D. Adaptation	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	
Respond to frequent changes in the environment or tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Aware of normal hazards and take appropriate precautions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Travel in unfamiliar places or use public transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Set realistic goals or make plans independently of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Juggle tasks and prioritize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
E. Responsibility and accountability					Yes	No
Is work pace without the pressure of deadlines?					<input type="radio"/>	<input type="radio"/>
Does the work involve occasional pressure to meet deadlines?					<input type="radio"/>	<input type="radio"/>
Does the work involve periodic pressure to meet deadlines?					<input type="radio"/>	<input type="radio"/>
Does the work involve significant pressures?					<input type="radio"/>	<input type="radio"/>

b) Before the plan member/employee stopped working, did the illness or injury cause him/her to change:

		Date (dd/mmm/yyyy)	Explanation
Job duties	<input type="radio"/> Yes <input type="radio"/> No		
Job performance	<input type="radio"/> Yes <input type="radio"/> No		
Equipment	<input type="radio"/> Yes <input type="radio"/> No		
Environment	<input type="radio"/> Yes <input type="radio"/> No		
Hours of work	<input type="radio"/> Yes <input type="radio"/> No		
Attendance	<input type="radio"/> Yes <input type="radio"/> No		

16 Other information

Please provide any additional information that you believe should be considered in assessing this plan member/employee's claim.

17 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature		Title
Telephone ()	Date (dd/mmm/yyyy)	

The information in this statement will become part of a Group Life and Health Benefits file which might be accessible by the plan member/employee or third parties to whom access has been granted or those authorized by law.