Claim for Disability Insurance
Employer's Statement
completed by immediate supervisor or manager
Policy no. 12500-G

PROTECTED once completed. Ce formulaire est disponible en français.

Please read all instructions and information; make sure that all sections are complete and accurate or this claim will be returned to you.

This form asks for information on the employee's specific duties. **It must be completed by the employee's immediate supervisor or manager. Please attach a current work description.**

Sun Life Assurance Company of Canada (referred to in this form as "Sun Life") must receive this form, the Compensation Advisor's Statement, the Employee's Statement and the Attending Physician's Questionnaire, before assessing this claim. Please complete this form in its entirety and submit it by fax ideally at least 60 days before the end of the elimination period but no later than 90 days after the end of the elimination period in order to avoid delays. If a claim form is submitted later than 90 days after the end of the elimination period, the employee may not be entitled to Disability Insurance Plan benefits if the delay impedes Sun Life's ability to assess the claim. See submission instructions at the end of the form.

To avoid overpayment, you must advise Sun Life immediately when the employee returns to work.

Clear

INFORMATION ABOUT EMPLOYEE'S DISABILITY AND JOB
(to be completed and signed by employee's immediate supervisor or manager)

Employee information

First name	Last name (Quebec residents: use maiden name, if applicable)		Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite number
City	Province	Postal code	Telephone number
Department or organization name			Department alpha code

Information about the disability and rehabilitation

Many employees who are disabled could be working productively if they were provided with help and encouragement toward this goal. When Sun Life feels that the employee is a suitable candidate for vocational rehabilitation, a Sun Life Health Management Consultant will contact the employing department to partner in identifying opportunities for the employee's return to work. The Disability Insurance Plan Board of Management and the Treasury Board of Canada Secretariat, on behalf of the policyholder, strongly support vocational rehabilitation and the efforts of departments, agencies and Sun Life to return employees to suitable and productive work.

Please identify the department or agency official Sun Life should contact if the employee is considered capable of vocational rehabilitation.

First name	Last name	Title	
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Telephone number	Fax number	Email address	

1. When did the employee's illness or injury first appear to affect his or her work? dd-mm-yyyy

Information about the disability and rehabilitation (continued)

2. From your observations, did the employee's ability to perform his or her job change? ☐ No ☐ Yes If yes, give details.

3. Were any changes made to the employee's job as a result of the illness or injury? ☐ No ☐ Yes If yes, give details.

4. If the employee could return to work on a reduced schedule or with a change in duties, would a position be available?
☐ No ☐ Yes If yes, give details.

Employment information

1. Employment status when last hired (check one)

	Full-time	Part-time
Indeterminate	☐	☐
Term of 6 months or less	☐	☐
Term of more than 6 months	☐	☐
Seasonal	☐	☐
Other (specify) _____	☐	☐

2. Location of employment ☐ Office ☐ Home ☐ Elsewhere (explain below)

3. Last day actively at work prior to disability? dd-mm-yyyy

4. If the employee remains actively at work but has reduced hours due to illness, please indicate the effective date of the reduced work schedule. dd-mm-yyyy

5. What was the employee's job title on the last day actively at work?

Please attach current job description.

6. Was the employee working modified duties prior to ceasing full-time work? If so, please describe the modifications.

7. From what date has the employee been appointed to this position? dd-mm-yyyy

8. a) How many hours was the employee assigned to work per week based on his or her substantive position?

b) On what date were these assigned hours authorized? dd-mm-yyyy

9. If the employee changed positions or assignments during the 12 months immediately before the last day worked, list the previous positions or assignments. Please also give the reasons for the changes and the effective dates of the changes.

10. a) Did the employee leave work for medical reasons? ☐ No ☐ Yes

b) If the employee is absent for any reason other than illness or disability (e.g. maternity leave), please give details.

Employment information (continued)

11. Was the employee on leave without pay prior to the disability? ☐ No ☐ Yes If yes, from what date? dd-mm-yyyy

12. a) Has the employee been permanently terminated? ☐ No ☐ Yes If yes, from what date? dd-mm-yyyy

b) Details

13. Has the employee returned to work? ☐ No ☐ Yes If yes, from what date? dd-mm-yyyy

14. Indicate the anticipated date of return to work. dd-mm-yyyy

15. Is the employee's substantive position still available? ☐ No ☐ Yes If no, give reason.

16. To your knowledge, is the employee now working elsewhere? ☐ No ☐ Yes If yes, give details.

Leave information (For questions that do not apply, please insert "N/A" in the blank space)

1. Please attach a copy of the employee's leave records for the past 12 months, along with an explanation of the codes and the current balance.

2. a) Does the employee have unused sick leave on the last day actively at work? (Include credits earned during elimination period.)

☐ No ☐ Yes If yes, how many days?

b) Has the employee been granted advanced sick leave? ☐ No ☐ Yes If yes, how many days?

3. What was/is the last date of paid sick leave? (1a + 1b) dd-mm-yyyy

4. If the employee was/is not allowed to use all available sick leave credits, give the date the credits would have ended and the reason(s) the employee was/is not allowed to use them. dd-mm-yyyy

5. Was any other type of paid leave granted? ☐ No ☐ Yes If yes, give date dd-mm-yyyy

Details

6. On what date will the paid leave end? dd-mm-yyyy

Workers' Compensation

1. If the employee's illness or injury is work related, has he or she applied for Workers' Compensation benefits? ☐ No ☐ Yes

Work environment and job activities

1. Does the employee's job require work in any of the following conditions?

Outside	☐ No	☐ Yes	If yes, what percentage of the time?	%
In extreme cold or heat	☐ No	☐ Yes	If yes, what percentage of the time?	%
In a damp or humid environment	☐ No	☐ Yes	If yes, what percentage of the time?	%
In a noisy environment	☐ No	☐ Yes	If yes, what percentage of the time?	%
In a dusty or unventilated environment	☐ No	☐ Yes	If yes, what percentage of the time?	%
Around toxic fumes	☐ No	☐ Yes	If yes, what percentage of the time?	%

2. Does the employee's job involve handling chemicals? ☐ No ☐ Yes
   If yes, please list the chemicals.

3. During the employee's normal routine, what percentage of time does the job require that the employee lift or carry the following weights?

	N/A	1 to 25%	26 to 50%	51 to 75%	76 to 100%
More than 50 lbs / 22.7 kg	☐	☐	☐	☐	☐
More than 20 lbs / 9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs / 4.5 kg	☐	☐	☐	☐	☐

4. During the employee's normal routine, what percentage of time does the job involve the following activities?

	N/A	1 to 25%	26 to 50%	51 to 75%	76 to 100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

5. How much time is the employee required to maintain the following positions or activities before changing position or activity?

	N/A	0 to 30 minutes	31 to 60 minutes	61 to 90 minutes	More than 90 minutes
Sitting at one time	☐	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐	☐

Work environment and job activities (continued)

6. During the average day, how many hours does the employee spend in the following positions or activities?

	N/A	0 to 2 hours	3 to 4 hours	5 to 6 hours	7 to 8 hours
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐

7. Please list any machine, tool or other equipment that the employee uses on the job and provide either the number of times per day that he or she uses it or the percentage of time that he or she spends using it, whichever is most applicable.

Machine, tool or other equipment	Number of times per day / Percentage of time

8. Cognitive/non-physical aspects of the job:

Does the employee have to answer complaints? ☐ No ☐ Yes

Is the employee primarily evaluated on production? ☐ No ☐ Yes

Does the employee work closely with co-workers? ☐ No ☐ Yes

Is the employee responsible for performance objectives and decision making within his or her particular department? ☐ No ☐ Yes

Number of people this employee supervises: ☐

What percentage of the employee's time is spent on the following activities?

Talking	Writing	Supervising other people
%	%	%

Please list any other relevant aspects of the job that may be considered stressful.

Additional remarks

Please provide any additional information that is relevant to this claim but has not been previously provided.

Declaration

To the best of my knowledge, the information given in this form is true and complete.

First name of of Immediate Supervisor	Last name	Title	
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Telephone number	Fax number	Email address	
Signature X		Date signed (dd-mm-yyyy)	

Submission process (two-steps)

1. To ensure prompt submission, please fax this form, along with any other information in support of the employee's claim that you would like to submit, to the confidential number that appears below. Alternatively, you can mail the documents directly to the Sun Life Assurance Company of Canada Montreal Group Disability Management Office. You do not need to mail information that you fax. Please retain the original copy for your records.
2. A copy must also be sent to the Public Service Pay Centre or your departmental Compensation services with a request they complete the Employer's Statement (Compensation Advisor) form 4811-E and send to Sun Life.

Montreal Group Disability Management Office
Federal Government Disability Insurance Plan
Sun Life Assurance Company of Canada
P.O. Box 12500 Station CV
Montreal, Quebec H3C 5T6

Fax: 1-866-639-7849

Keeping your information confidential

At all time, the information collected will be protected under the provision of the Personal Information Protection and Electronic Documents Act (PIPEDA).