Government of Canada | Gouvernement du Canada

Claim for Disability Insurance
Employee's Statement
Policy No. 12500-G

PROTECTED *once completed*

IMPORTANT

- Please fill in this form completely and return it to your Human Resources Office. In addition, fill in Part 1 of the Employee's Medical Information and Attending Physician's Statement (TBS/SCT 330-304) and provide it with Part 2 to your attending physician. Failure to do so may result in the delay of any payments to which you may be entitled.
- Please answer all questions fully; use separate sheets if necessary and attach them to the appropriate forms. If you have any questions at all, please do not hesitate to contact your Human Resources Office.
- You must return this completed form to your employer within 8 weeks from the date you became disabled.
- You **must** promptly notify Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), if:
  - your medical condition improves so that you are able to work;
  - you begin working again either as an employee or as a self-employed person; or
  - you change your address.

About you

Last Name	Given Name	Maiden Name (for Quebec residents)
Street Address		
City	Province	Postal Code
Home Telephone No. ( )	Date of Birth (Day / Month / Year) / /	Sex ☐ Male ☐ Female ☐ Ms. ☐ Mrs. ☐ Miss
Social Insurance No. (for tax purposes)	Certificate No. CG-	

About your employment

Supervisor's Name	Telephone No. ( )
Name and Address of Department	

1. From what date did your illness or injury prevent you from working? Day / Month / Year

2. When do you expect to be able to return to your own job? Day / Month / Year ☐ Full-time ☐ Part-time

3. When do you expect to be able to do any other job? Day / Month / Year ☐ Full-time ☐ Part-time

4. Have you tried to return to work already? ☐ No ☐ Yes If yes, please answer the following questions:

When did you return to work? Day / Month / Year **to** Day / Month / Year

Did you return to: ☐ your own job ☐ a new job or modified duties

Did you return: ☐ full-time ☐ part-time

5. Have you been involved in any activities for wage or profit since you became disabled? ☐ No ☐ Yes If yes, please give details.

About your illness or injury

1. **a)** Are you confined to the house? ☐ No ☐ Yes

b) Are you bed confined? ☐ No ☐ Yes

c) Are you confined to a hospital? ☐ No ☐ Yes

2. Did the doctor recommend a change in, or certain restrictions on, the type of work that you could do? ☐ No ☐ Yes If yes, please describe the change and the date the change was made.

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Illness or injury as a result of an accident

1. Is your illness or injury the result of an accident? ☐ No ☐ Yes If yes, answer the following questions:

2. Where did the accident happen? ☐ At home ☐ At work ☐ Other (please explain where) _____

3. When did the accident happen? Day / Month / Year

4. How did the accident happen?

_____

5. If it was a motor vehicle accident, were you the driver? ☐ No ☐ Yes

6. Are you taking legal action against the other party involved in the accident?

☐ Yes

Name of your Lawyer		
Address		Telephone No. ( )
City	Province	Postal Code

☐ No Please explain why you are not taking legal action.

_____

_____

_____

Workers' Compensation Benefits (Please attach a copy of any correspondence relating to your workers' compensation claim.)

1. If your illness or injury is work related, have you applied for any workers' compensation benefits? ☐ No ☐ Yes If no, please explain. _____

2. Are you receiving, or do you expect to receive, workers' compensation benefits? ☐ No ☐ Yes If yes, please continue:

What is the claim number? _____ What is the weekly benefit amount? $

3. Have you received a permanent disability award? ☐ No ☐ Yes If yes, when did you receive it? Day / Month / Year

From what date is it effective? Day / Month / Year

Was it a monthly benefit? ☐ No ☐ Yes If yes, what was the amount? $

Was it a lump-sum settlement? ☐ No ☐ Yes If yes, what was the amount? $

4. If your claim has been denied or terminated, have you appealed the decision?

☐ No If no, why not?

☐ Yes If yes, when did you appeal it? Day / Month / Year

What type of appeal was it (if known)?

☐ Oral ☐ Board of Review ☐ Medical panel

☐ Medical Review ☐ Other : _____

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Canada / Quebec Pension Plan benefits

1. Have you applied for a Disability Benefit under the Canada/Quebec Pension Plan?

☐ Yes When did you apply?

Day	Month	Year
/	/	

☐ No Please give reasons to explain why you have not applied.

_____

_____

_____

2. If you have applied for a Disability Benefit, has your application been approved?

☐ Yes Please include a copy of the Notice of Entitlement with this form.

☐ No If you have been denied or if you are appealing a decision, please explain and give the dates of the denial and of the appeal. Also include a copy of the decision letter.

_____

_____

Your other income

Please list any amounts of money you are currently receiving or expect to receive from all other sources not previously mentioned. We may take some of these amounts into consideration when we calculate your Disability Insurance Benefit.

	Name of Source	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per month
		Yes	No	Receiving	Expect to receive	
Other Group/Association Insurance Plans		☐	☐	☐	☐	
Other Government Plans (not limited to Canada)		☐	☐	☐	☐	
Auto Insurance (Provincial)		☐	☐	☐	☐	
Public Service Superannuation Act (PSSA)	N/A	☐	☐	☐	☐	
Crime Victims Benefits	N/A	☐	☐	☐	☐	
Other (please give details)		☐	☐	☐	☐	

Returning to work

Returning to work is an important part of your treatment program. If you qualify, the Insurer has a program to assist you in your return to work. You may be contacted by a Rehabilitation Specialist representing the Insurer. Since the Plan provides a different definition of disability between the first 24 months of benefits and thereafter, it is of substantial benefit for you to use the period while you are receiving financial support from the Plan to prepare for a return to the workforce. This is of particular importance if you are considered disabled only with respect to your own occupation.

1. What has your doctor told you about returning to work?

_____

_____

2. Have you discussed returning to work with your employer, either to your own job as it existed before, your own job with a change in duties, or to another position?

☐ No

☐ Yes If yes, on a ☐ Part-time basis? ☐ Full-time basis? ☐ Or on a graduated part-time to full-time basis?

Please give details.

_____

_____

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Your work history (Attach a résumé, if available.)

From	To	Employer	Job Title and Duties

Your education and acquired skills

1. What is the highest grade level that you completed or the highest degree that you obtained?

2. Please describe other educational training or skills upgrading. This includes on-the-job training and special interest courses, etc. In addition, list any other skills you have acquired. These skills may include typing, computer skills, operation of equipment, supervisory skills, special licences, etc. They may also include skills acquired through volunteer work, hobbies and interests. Please use extra sheets, if necessary.

_____

_____

_____

_____

Automatic deposit of your disability payment

Should you be entitled to a Disability Insurance Plan benefit, for your convenience, it can be deposited directly into your account at any bank, trust company, caisse populaire or credit union in Canada. If you would like payments deposited into a chequing account, please attach a **void cheque** from that account. If you prefer that your payments be deposited into a savings account, please provide details.

Name of Financial Institution	Address

Institution Number				Branch Number						Account Number									

Your declaration and authorization

- I certify that the statements on this form are true and complete.
- I authorize my employer, Sun Life Assurance Company of Canada and any person or organization who has any personal or medical information about me, including health professionals and institutions, investigation agencies, insurers and persons performing services for the Insurer, to exchange information needed for underwriting, administration or paying claims.
- I agree to a personal investigation in connection with this claim.
- I agree to notify Sun Life Assurance Company of Canada promptly if there is a change in my condition that affects my ability to return to work or a change in my monthly income.
- I realize that my disability payments will be reduced by other income such as, but not limited to, a Disability Benefit under the Canada Pension Plan/Quebec Pension Plan and/or the *Public Service Superannuation Act*.
- I agree that a photocopy of this authorization is as valid as an original.

Name (Please Print)	Signature	Date

After you have completed this form, please return it to your employer. Your employer will send the form along with the Employer's Statement to the Insurer.

Telephone contact

When the Insurer receives your claim, you may receive a phone call from the individual responsible for its assessment. This will be your opportunity to discuss and clarify any issues relating to your claim.
(Please note: it may be determined that a call is not required.)

Provision of the information requested in this form is voluntary. The information is being collected by the Treasury Board on behalf of the Insurer for the purpose of the administration of the Disability Insurance Plan. This information is essential to the Insurer's decision concerning your claim. Refusal to respond fully may result in disability benefits not being approved. This information will be stored in *Personal Information Bank number PSE 901 and PWGSC-PCE-703*. It is protected from disclosure to unauthorized persons/agencies pursuant to the provisions of the *Privacy Act*. Under the *Act*, you have the right to request access to your personal information held by a federal government institution, and to request corrections should you believe the information contains errors or omissions.