



**BRITISH COLUMBIA PROVINCIAL
LONG TERM DISABILITY PLAN
EMPLOYER BENEFIT STATEMENT**

EMPLOYEE NO.	EMPLOYER NO.	EMPLOYER NAME	ASSOCIATION
LAST NAME	FIRST NAME	MIDDLE NAME	FIRST NAME USED
EMPLOYEE SOCIAL INSURANCE NO.	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH YEAR/MONTH/DAY	Maximum retirement age: _____ Years (60 or 65) Maximum retirement year: _____

MAILING ADDRESS – Include street, city, province, country and postal code

RESIDENTIAL ADDRESS IF DIFFERENT FROM MAILING – Include street, city, province, country and postal code	RESIDENTIAL PHONE NO. ()
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CONTACT TYPE – IF APPLICABLE (e.g. power of attorney or committee)	CONTACT NAME
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CONTACT ADDRESS – Include street, city, province, country and postal code	CONTACT PHONE NO. ()
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WORK ADDRESS – Include street, city, province, country and postal code	WORK PHONE NO. ()
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PAYROLL OFFICE INFORMATION		PERSONNEL ADVISOR INFORMATION	
PAYLIST NO.	PAYROLL CONTACT NAME	PERSONNEL ADVISOR NAME	
PHONE NO. ()	FAX NO. ()	PHONE NO. ()	FAX NO. ()
OFFICE ADDRESS – Include street, city, province, country and postal code		OFFICE ADDRESS – Include street, city, province, country and postal code	
PAYROLL CONTACT E-MAIL ADDRESS		PERSONNEL ADVISOR E-MAIL ADDRESS	

EMPLOYEE STATUS

1 REGULAR STATUS YES NO
REGULAR STATUS DATE YEAR/MONTH/DAY

By conversion per Union agreement? YES NO

If YES, indicate date 1827 hours in 33 bi-weekly pay periods completed: YEAR/MONTH/DAY

AND

Confirm employee maintained 1200 hours in 12 months prior to STIIP start date): YES NO

2 LAYOFF STATUS YES NO
LAYOFF DATE YEAR/MONTH/DAY

3 SCHEDULED TO BELAID OFF YES NO

HIRE DATE YEAR/MONTH/DAY	Is original hire date after April 1, 1987? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete and submit 1) List of Absences from original date of hire OR 2) confirmation of dates completed 12 months of active service without illness or injury.
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Does this employee contribute to the BC Public Service Pension Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the employee appointed under the <i>Public Service Act</i> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	If this employee is appointed under an Act other than the <i>Public Service Act</i> , define the Act
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Does employee work full or part time? <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	If part time, does the position provide at least half time work on a regular basis? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this a seasonal employee? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Provide bi-weekly full time or part time hours	Provide work schedule (e.g., Monday, Wednesday, Friday)
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Forward a detailed job description which can be used by the claim adjudicating agency to compare against the employee's medical limitations to determine the degree of disability.

CLASSIFICATION	CLASSIFICATION CODE	SALARY GRID LEVEL	SALARY STEP	If not at top step, provide next increment date	YEAR/MONTH/DAY	MANAGEMENT COMPA-RATIO
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Has employee filed a WCB Claim for this absence? YES NO *If YES, provide claim number* _____

Is there an ICBC Claim for this absence? YES NO

Dates of WCB payment (Include any previous absences paid for the same claim)
If WCB payments have terminated or were denied, send copy of WCB letter

FROM YEAR/MONTH/DAY	TO YEAR/MONTH/DAY	FROM YEAR/MONTH/DAY	TO YEAR/MONTH/DAY	FROM YEAR/MONTH/DAY	TO YEAR/MONTH/DAY
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Last day worked (prior to the STIIP start date) YEAR/MONTH/DAY FULL DAY HALF DAY

Is this employee on Maternity/Parental Leaves, Leaves of Absences, Temporary Appointments, or is there anything else illness and Injury Benefits should be aware of for LTD purposes? YES NO *If YES, specify:* _____

Are STIIP benefits currently being paid to this employee? YES NO *If NO, provide reason:* _____

Start Date of STIIP/WCB period: YEAR/MONTH/DAY <input type="checkbox"/> FULL DAY <input type="checkbox"/> HALF DAY	NOTE: This date is the first scheduled work day the employee was unable to work for the current illness.	Date STIIP payments commenced if other than STIIP period start date: YEAR/MONTH/DAY
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End date of STIIP/WCB period: YEAR/MONTH/DAY <input type="checkbox"/> FULL DAY <input type="checkbox"/> HALF DAY	Sick bank balance at end of STIIP/WCB? _____ DAYS
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Last day on Employer Payroll (after expiration of sick bank credits) YEAR/MONTH/DAY _____ PORTION OF DAY

If this employee has returned to work on a trial or has not requalified for STIIP, the following are the particulars and dates:

SALARY INFORMATION

NOTE: All salaries should be as at the last day of the STIIP/WCB period (NOT 75% STIIP amount, include any salary increases during the STIIP period).

BIWEEKLY SALARY \$	BIWEEKLY ADDITIONAL PAY AMOUNT (SPP, CAD, AMA ONLY) \$	BIWEEKLY ADDITIONAL PAY TYPE (SPP, CAD, AMA ONLY)	TOTAL BIWEEKLY SALARY \$	MONTHLY SALARY \$
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COMPLETED BY:

NAME	E-MAIL ADDRESS	PHONE NO. ()	FAX NO. ()
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SIGNATURE – I certify the information on this form has been verified and is correct.	DATE SIGNED YEAR/MONTH/DAY
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