Plannera Disability Income Plan
Application for Group Long Term Disability Benefits - Employer's Statement - Part A

Important:
The completed Employer's part A, part B and Employee's Statements are required before claim assessment can commence. Please ensure they are completed and forwarded to Plannera – Benefits at least 13 weeks prior to the end of qualifying period. **Benefits may be delayed if this guide is submitted later than 13 weeks prior to the end of the Elimination Period.** Canada Life's Privacy Guidelines and applicable law allow claimants to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the claimant.

EMPLOYER IDENTIFICATION

Name			Group Policy Number	Division Number
			57402	
Address: Street & Number	PO Box	City	Province	Postal code
Telephone Number		Employer Email Address		

EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	CL Employee I.D. Number	Social Insurance Number

EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY)

Last physical day employee was at work (MM/DD/YY)

Employment Class: Is the Employee: **Please complete each of lines a), b) and c) in full.**

a) ☐ Full time: Number of hours worked per week _____
☐ Part time: Number of hours worked per week _____

b) ☐ Temporary ☐ Seasonal ☐ Permanent ☐ Contract

c) ☐ Hourly ☐ Salaried ☐ Commissioned

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Temporary Lay-off
☐ Quit ☐ Retired ☐ Other ☐ Work related accident or sickness

Has employee returned to work? ☐ Yes ☐ No

If yes, date: (MM/DD/YY) _____

If not, is a return to work date known?

☐ Yes ☐ No If yes, date (MM/DD/YY) _____

Has employment terminated? ☐ Yes ☐ No If yes, date (MM/DD/YY) _____

Pension Plan Information

Name of Pension Plan _____

Monthly employee contribution _____ % Monthly employer contribution _____ %

Union Dues Information

Name of Union and Barganing Unit

_____

Original effective date of the employee's basic LTD insurance (MM/DD/YY) _____

EARNINGS AND BENEFITS INFORMATION

Please answer the following questions.

Employee's basic monthly earnings (as defined in the contract): $ _____

Date disability premiums will be paid to (MM/DD/YY) _____ **OR**

Premiums paid to the end of the QP: ☐ Yes

Amount of last paid disability premium via payroll $ _____

Were premiums paid through LOA to Plannera? ☐ Yes ☐ No

Premiums remitted on full time salary for part time employees: ☐ Yes ☐ No ☐ N/A

Last date EE was/will be paid sick leave (MM/DD/YY) : _____

Is the employee receiving auto wage replacement ☐ Yes ☐ No

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☐ Yes ☐ No

If yes, percentage of employment income that is tax exempt _____ %

WORKER'S COMPENSATION BOARD (WCB)

Is the employee receiving WBC income?

☐ Yes ☐ No If yes, complete the following: Effective date: _____

Amount: _____

Are the following being deducted:

Union Dues: ☐ Yes ☐ No

Last date deductions will be made by the employer _____

Employee pension: ☐ Yes ☐ No

Last date deductions will be made by the employer _____

Employer pension: ☐ Yes ☐ No

Last date deductions will be made by the employer _____

Please attach copies of all correspondence from WCB received to date.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ Date: _____

Name (please print): _____ Title: _____

Phone: _____ Email: _____

Clear