ALBERTA BLUE CROSS®

APPLICATION FOR BENEFITS
EMPLOYER STATEMENT

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 587-756-8631 or 1-800-763-6206
Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.
It is the responsibility of the insured member to submit the Employee Statement and Attending Physician Statement.

Group/policy number

Section

☐ Short-term disability (weekly indemnity)
☐ Long-term disability
☐ Waiver of premium

Employee (plan member) information

Last name	First name	Social insurance number	Middle initial	Birth date (YYYY-MM-DD)	Gender ☐ M ☐ F

ID number	Mailing address	City/town	Province	Postal code

Home phone number	Work phone number	Email address

Position information *(attach the current job description, "Job Description – Disability Application")*

Position/job title (as of last day worked) ☐ Part-time ☐ Full-time

Date last worked (YYYY-MM-DD)

Employment start date (YYYY-MM-DD)

Employee's effective date of coverage (YYYY-MM-DD)

Basic regular gross earnings (pre-disability)

$ ____________________

☐ Hourly ☐ Weekly ☐ Monthly ☐ Commission basis

Confirmed return to work (RTW) date (YYYY-MM-DD) or Expected return to work (RTW) date (YYYY-MM-DD)

Regular work schedule

Usual number of **hours** worked each week ____________

Usual scheduled work days each week

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Usual scheduled work hours each shift ________ a.m. / p.m. to ____________ a.m. / p.m.

**If this position requires a varied schedule or rotational shift work, please provide details in the additional information section found on page two.*

Capacity of RTW ☐ Full-time ☐ Part-time
☐ Regular work ☐ Modified duties

If deemed medically supported and/or appropriate by Alberta Blue Cross, will you accommodate a return to work plan?

☐ Yes ☐ No (please specify)

Is the employee's job being held for him/her?

☐ Yes ☐ No (please specify)

Are there any other jobs in your organization which the employee may be qualified to do? ☐ Yes ☐ No

Please specify

Other sources of income *(since the last day worked)*

☐ Salary continuation (YYYY–MM–DD) to (YYYY–MM–DD)

☐ Paid sick leave (YYYY–MM–DD) to (YYYY–MM–DD)

☐ Paid vacation (YYYY – MM – DD) to (YYYY–MM–DD)

☐ Other ______________________ (YYYY–MM–DD) to (YYYY–MM–DD)

Disability information *(attach all medical certificates and notes received in relation to this absence)*

Has the employee been provided with full details of benefits under this plan? ☐ Yes ☐ No

Is this condition due, or related to, occupational illness or accident (past or present)? **(If yes, attach copy of worker's compensation correspondence)** ☐ Yes ☐ No

If yes, state how it occurred

Has the employee applied for any other benefits, such as Workers Compensation Board, automobile insurance, employment insurance, private or public pension, etc.?

☐ Yes, Carrier ________________________________ ☐ No

If yes, indicate the date of application, claim/file number, decision and claim/file status (attach applicable correspondence)

Has the employee ever submitted an application for similar causes? ☐ Yes ☐ No

If yes, include dates paid and insurance carrier

From (YYYY-MM-DD)	To (YYYY – MM – DD)	Carrier	From (YYYY-MM-DD)	To (YYYY-MM-DD)	Carrier

Additional information

Provide any additional information which may be of value in consideration of this application for benefits (for example, accomodation prior to leave of absence, job performance, attendance pattern, workplace issues or conflict)

I hereby declare that the answers to the above questions are accurate and complete

Name

Position/title

Phone number

Fax number

Email address

Signature

Date (YYYY-MM-DD)

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.

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