Health Shared Services Saskatchewan - 3sHealth
Employee Benefits
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Regina, SK S4P 0R7
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Toll Free: 1-866-278-2301
E-mail Address: disability@3shealth.ca

Application for Continuation of Disability Income Plan Benefits

PART 1: EMPLOYEE INFORMATION

Name _____ Benefit ID# _____

Claim ID # _____ Date of Birth ___/___/___ (dd / mm / yy)

Has your address changed? ❑ No Telephone _____

❑ Yes, new address _____ E-mail Address _____

Describe your current typical daily activities:

Describe any change in your medical condition(s) since last report:

Please list the names of all physicians and medical practitioners currently involved in the investigation and treatment of your medical condition(s) and the appointment dates since you last provided an update:

During your current absence from work, have you participated in any type of activity which could be considered gainful employment? (eg. home business, farming, spouse's business, etc.) ❑ No ❑ Yes, describe:

Have you received income from any of the sources indicated below during the period of your absence from work ❑ No ❑ Yes

If so, please check the appropriate box and note that you must provide with this form a copy of correspondence that indicates the type of income or benefit received, the amount received, and the effective date of the income or benefit received, if you have not already submitted this information to 3sHealth.

❑ Auto Insurance (SGI) ❑ Canada Pension Plan (CPP) (disability and/or retirement) ❑ Private Insurance

❑ Workers' Compensation (WCB) ❑ Employment Insurance (EI) ❑ Other Income: (specify) _____

When do you expect to return to your regular occupation with your employer? _____

If your employer is able to accommodate your medical limitations by modifying the amount of time you work and/or the duties you are expected to perform, would you be willing to participate in a return to work program?

❑ Yes ❑ I am already in a return to work program and/or am working with a vocational rehabilitation consultant.

❑ No, please explain:

_____

_____

I hereby certify that the above answers are full and true to the best of my knowledge and belief, and I am aware that any intentional misrepresentation of facts could result in the immediate termination of benefits.

I authorize any government agency including the Workers' Compensation Board, Health Canada and Saskatchewan Government Insurance to furnish to Health Shared Services Saskatchewan – 3sHealth any information required in connection with this claim. I authorize and request that any physician or health care practitioner provide 3sHealth with any information requested in connection with this claim. A photocopy of this authorization will be considered valid.

Note: Your failure to fully complete this form may result in our returning the form to you and in a delay in our evaluation of your application.

Signature _____ Date ___/___/___ (dd / mm / yy)

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE REVERSE SIDE OF THIS FORM

Patient's Name: _____

PART 2: PHYSICIAN'S INFORMATION

1. Diagnosis(es) of the medical condition(s) primarily affecting your patient's ability to perform his/her occupation:

2. Please describe any changes that have occurred in your patient's medical condition(s) since the last statement. Please indicate any medical investigations or consultations that have been completed or are being arranged. Please provide dates and attach copies of specialists' reports and test results that are relevant to the medical condition(s) causing absence.

3. Please describe the specific medical limitations or restrictions that are preventing your patient from working.

4. Please indicate the current treatment program by checking the appropriate box and describe in the space provided:

- ❑ Names and dosages of medications _____
- ❑ Interactive treatments (e.g.: physiotherapy, counseling, etc.) _____
- ❑ Date and type of surgery _____
- ❑ Hospital admission/discharge dates _____
- ❑ Future plans for treatment

5. What is the frequency of your patient's consultation with you or other medical practitioners since the last statement?

6. To assist in planning your patient's successful return to employment, please outline any specific modifications to job duties or schedules that you would impose on your patient's return to the workforce. *Please be specific with regard to dates, modifications and duration.*

7. While we realize predicting a recovery date is difficult, we require an indication of the anticipated length of the absence from work. Please provide the date you anticipate your patient will return to work or the expected period required for recovery _____

   If this is unclear at this time, please indicate the next date you will be assessing your patient _____

8. Please feel free to provide any other information that may be relevant to your patient's medical condition and absence from work.

**** It is the patient's responsibility to pay for the costs associated with having this form completed ****

Please legibly print, type or stamp your name, specialty and address:

Tel: _____

Fax: _____

Email: _____

Signature _____ Date ____/____/____ (dd / mm / yy)

3sHealth Employee Benefits is committed to protecting the privacy of your personal information. We collect and use your personal information to determine your eligibility for coverage and to administer the benefit plans. We limit access to your personal information to 3sHealth Employee Benefits staff, to any third party authorized by 3sHealth who requires it to administer your benefits, to persons to whom you have granted access, and to persons authorized by law.