Health Shared Services Saskatchewan - 3sHealth
Employee Benefits
700-2002 Victoria Ave
Regina, SK S4P 0R7
T. 306-347-5559 F. 306-347-5910
Toll Free: 1-866-278-2301
E-mail Address: disability@3shealth..ca

Employee's Initial Application Disability Income Plan Benefits

PART 1 – EMPLOYEE INFORMATION

Name | **Home Telephone Number** | **Benefit ID**

E-mail Address:

Address | **City** | **Province** | **Postal Code**

Social Insurance Number | **Date of Birth** ____/____/____ **(dd / mm / yy)** | **Gender** ❑ **Female** ❑ **Male**

PART 2 – CLAIM INFORMATION

Describe the illness/injury for which the claim is being made _____

Describe your current limitations due to the illness/injury _____

What date were you first unable to work due to illness/injury ____/____/____ (dd / mm / yy)

Please list the names of the physician(s) treating you for your illness/injury

Name of Physician	Specialty	Date Last Attended	Reason
		____/____/____ (dd / mm / yy)	
		____/____/____ (dd / mm / yy)	
		____/____/____ (dd / mm / yy)	

Prior to your present absence from work, had you received treatment for the same or for a related illness/injury ❑ No ❑ Yes

If yes, please list the physician(s) who treated you

Name of Physician	Specialty	Date Last Attended	Reason
		____/____/____ (dd / mm / yy)	
		____/____/____ (dd / mm / yy)	
		____/____/____ (dd / mm / yy)	

Is your illness/injury caused wholly or in part by (note that you must attach a copy of any related correspondence received from WCB or SGI):

Pregnancy	❑ No	❑ Yes, date maternity leave will commence	____/____/____ (dd / mm / yy)
Work duties/responsibilities	❑ No	❑ Yes, date Workers' Compensation Board application submitted	____/____/____ (dd / mm / yy)
Motor vehicle accident	❑ No	❑ Yes, date SGI application submitted	____/____/____ (dd / mm / yy)
Other type of accident	❑ No	❑ Yes, type _____	

Is legal action pending against a third party who is or may be responsible for your illness/injury ❑ No ❑ Yes, name of your lawyer _____

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) _____

PART 3 – OCCUPATIONAL INFORMATION

Since the date you were unable to work, have you participated in any type of activity which could be considered employment (e.g., home business, farming, spouse's business). ❑ No ❑ Yes, describe _____

_____

When do you expect to return to your regular occupation at the health organization where you are employed _____

Describe the responsibilities and duties of your job that your illness/injury prevents you from performing _____

_____

Describe your present typical daily activities _____

_____

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

❑ Yes, please explain ❑ No, please explain

_____

_____

_____

PART 4 – EDUCATIONAL AND OCCUPATIONAL HISTORY

Highest grade completed _____ Year _____

Please list all certificates, diplomas, degrees, etc. attained through a post-secondary institution (correspondence studies included)

_____

_____

_____

_____

Please list any other courses taken such as work-related and/or personal development courses, or any courses which have increased your skill inventory (e.g. typing, word processing, medical terminology, accounting, etc.)

_____

Please list your work experience, starting with your most recent position

Position/Title	Type of Work	Date Commenced	Number of Years
		/ / (dd / mm / yy)	
		/ / (dd / mm / yy)	
		/ / (dd / mm / yy)	

PART 5 – STATEMENT AND AUTHORIZATION

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, 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 shall be valid.

I acknowledge and understand that all of my personal information collected by 3sHealth, including the personal information contained in this application form and any personal information disclosed by my employer, physicians or other medical practitioners which is required by 3sHealth in support of this application form is being collected by 3sHealth for the purpose of administering the 3sHealth Plan, and to meet 3sHealth's obligations under applicable law, and I hereby authorize and consent to the collection, use and disclosure of my personal information including my Social Insurance Number by 3sHealth for such purposes. I acknowledge and agree that my consent to the foregoing is a fundamental condition of 3sHealth providing administration and other services to myself in connection with the 3sHealth Plan, and that my consent may not be revoked or withdrawn without limiting or terminating those services**.**

Note: Disability benefits are only paid by direct deposit to your bank or other financial institution. Please be sure to attach a completed Payroll Data Form (form number DIP 15) along with a void cheque or encoded deposit slip.

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)

3sHealth Employee Benefits is committed to protecting the privacy of your personal information. 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.