



Employer's Initial Application Disability Income Plan Benefits

PART 1 - EMPLOYEE INFORMATION

Employee's Name		Position/Title		BID #	
Employee's Address		City	Province	Postal Code	
Facility Where Employee Works					
Employee's Home Telephone Number	Social Insurance Number	Date of Birth / / (dd / mm / yy)		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Affiliation <input type="checkbox"/> Saskatchewan Union of Nurses (SUN) <input type="checkbox"/> Service Employees International Union (SEIU) <input type="checkbox"/> Canadian Union of Public Employees (CUPE) <input type="checkbox"/> Out of Scope <input type="checkbox"/> Other Union _____			Disability Income Plan Enrollment <input type="checkbox"/> Saskatchewan Union of Nurses (SUN) <input type="checkbox"/> Service Employees International Union (SEIU) <input type="checkbox"/> Canadian Union of Public Employees (CUPE) <input type="checkbox"/> General <input type="checkbox"/> Regina Civic Plan <input type="checkbox"/> None		

PART 2 - CLAIM INFORMATION

Work-related illness/injury No Yes, date Workers' Compensation Board application submitted / / (dd / mm / yy)

Pregnancy-related illness No Yes, maternity leave commences / / (dd / mm / yy)

Please check benefits the employee is claiming for at this time

Disability Income Plan Benefits

Waiver of Premium for all 3sHealth benefit plan coverage while receiving income replacement from another source

PART 3 - PAYROLL INFORMATION

Employment Status (Home Position)* Full-time Part-time Casual Regular earnings \$ _____ per hour

Date employee last worked / / (dd / mm / yy) Sick leave accumulated at date of disability _____ Days Hours

Date sick leave expired/will expire / / (dd / mm / yy) Date employee has been/will be paid to / / (dd / mm / yy)

Please circle scheduled days in week of final payment Sun Mon Tues Wed Thurs Fri Sat

Has employee returned to work? No Yes, date of return to work / / (dd / mm / yy)

Please circle scheduled days in week of return to work Sun Mon Tues Wed Thurs Fri Sat

Number of hours in regular work week _____ Average number of hours in regular workday _____

Date employment commenced / / (dd / mm / yy) Has employee been terminated? No Yes, date / / (dd / mm / yy)

Date employee joined 3sHealth Disability Income Plan / / (dd / mm / yy)

Is employee a member of the Saskatchewan Healthcare Employees' Pension Plan? No Yes

Employee is a member of: PEPP PSSP Contribution % _____

For All Employees: Provide the total of regular paid hours in the 52 week period immediately preceding the employee's last day of work _____
 See document #50-003-11 of 3sHealth's Employee Benefits Policy and Reference Manual for definition of insurable earnings (regular paid hours)

List all periods of approved unpaid leave of absence in the 52 week period immediately preceding the employee's last day of work _____

* If employee was working in a position other than home position at date last worked, please provide all details in the comments section on page 2

PART 4 – OCCUPATIONAL INFORMATION**Note:** A current job description must be attached to this formCan employer provide modified duties to accommodate the employee's limitations? Yes, please explain No, please explain:

Comments: please provide any comments which would assist in the adjudication of the employee's eligibility for benefits

PART 5 – GROUP LIFE COVERAGE INFORMATIONIs the employee enrolled in the 3sHealth Group Life Insurance Plan? Yes No

Group Life Plan Join Date: ____ / ____ / ____ (dd / mm / yy)

Basic Group Life Insurance Amount: \$ _____ Based on 2x 1.5x 1x (up to the next \$1,000) (2x is the normal multiplier for employees hired after 1982)

Optional Group Life Insurance Units: _____

Voluntary AD&D Insurance Units: _____

Dependant Life Insurance: Yes No**PART 6 – EMPLOYER INFORMATION**

Employer/Health Region _____ Organization Number _____

Facility where employee works (if different from Employer/Health Region) _____

Name of Payroll/Benefits Contact _____

Telephone Number _____ Fax Number _____

Address _____

E-mail Address _____

Note: Disability Income Plan benefit payments will be paid by direct deposit. Please ensure that your employee, when submitting the Initial Application form, also submits a Payroll Data Form with an attached void cheque or encoded deposit slip.

Signature _____ Date _____ (dd / mm / yy)