December 2, 2019

To: **Benefit Administrators / Human Resource Personnel**

From: **Kathryn Sandstra**
Specialist, Employee Benefit Plans

Re: **NEW! Disability Income Plan Application Forms**

Simplifying our forms is a commitment we made in the Path to Health Claims Management Re-Design Project.

We are pleased to share with you the newly simplified disability income plan application forms including:

- Employer's Initial Application Disability Income Plan Benefits
- Employee's Initial Application Disability Income Plan Benefits (please note that the Payroll Data form is no longer a separate form and is integrated into this new form)
- Disability Income Plan – Integrated Earnings Report
- Claim Closure Form Disability Income Plan Benefits

The new forms are in a fillable pdf format and are available on our website www.3shealth.ca. The forms can be filled out electronically or in hard copy, whichever you prefer. Once printed and signed, your completed forms can be scanned and emailed to ebp@3shealth.ca or sent by regular mail.

We are enclosing copies of the new forms for reference. Please destroy any existing stock of the old forms you may have on hand, including the disability application booklet.

We welcome your feedback on the new forms! Please contact Kathryn Sandstra by telephone at 1-306-347-5598 or email us at ebp@3sHealth.ca with any questions or feedback on the new disability income plan application forms.

3sHealth – Employee Benefits
700-2002 Victoria Ave Regina, SK S4P 0R7
T. 306-347-5519 F. 306-347-5910
Toll Free: 1-866-278-2301
Email: ebp@3sHealth.ca

Employer's Initial Application Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYER

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#

Is the employee's leave due to a work-related illness/injury? ❑ No ❑ Yes, provide the date you sent the application to WCB

PAYROLL INFORMATION

Position #1 Title: ❑ **Full-time** ❑ **Part-time** ❑ **Casual** **Rate of Pay:**

Date employee last worked dd/mm/yy	What is the date the employee was/will be paid to? dd/mm/yy

Please check the scheduled days in week of final payment ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days

Has the employee returned to work? ❑ No ❑ Yes, provide the date the employee returned to work dd/mm/yy

Please check the scheduled days in the week of return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days

Please check the pension plan the employee belongs to: ❑ SHEPP ❑ PEPP ❑ PSSP ❑ CIVIC Contribution %

Provide the total number of regular paid hours in the 52 week period immediately preceding the employee's last day of work

List all periods of approved unpaid leave of absence or suspension greater than 31 days in the 52 week period immediately preceding the employee's last day of work			

Position #2 Title: ❑ **Full-time** ❑ **Part-time** ❑ **Casual** **Rate of Pay:**

Date employee last worked dd/mm/yy	What is the date the employee was/will be paid to? dd/mm/yy

Please check the scheduled days in week of final payment ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days

Has the employee returned to work? ❑ No ❑ Yes, provide the date the employee returned to work dd/mm/yy

Please check the scheduled days in the week of return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days

Please check the pension plan the employee belongs to: ❑ SHEPP ❑ PEPP ❑ PSSP ❑ CIVIC Contribution %

Provide the total number of regular paid hours in the 52 week period immediately preceding the employee's last day of work

List all periods of approved unpaid leave of absence or suspension greater than 31 days in the 52 week period immediately preceding the employee's last day of work			

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#

Position #3 Title: ❑ **Full-time** ❑ **Part-time** ❑ **Casual** **Rate of Pay:**	
Date employee last worked dd/mm/yy	What is the date the employee was/will be paid to? dd/mm/yy
Please check the scheduled days in week of final payment ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days	
Has the employee returned to work? ❑ No ❑ Yes, provide the date the employee returned to work dd/mm/yy	
Please check the scheduled days in the week of return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ No Scheduled Days	
Please check the pension plan the employee belongs to: ❑ SHEPP ❑ PEPP ❑ PSSP ❑ CIVIC Contribution %	
Provide the total number of regular paid hours in the 52 week period immediately preceding the employee's last day of work	

List all periods of approved unpaid leave of absence or suspension greater than 31 days in the 52 week period immediately preceding the employee's last day of work			

ADDITIONAL COMMENTS

Please provide any additional information that may assist in the adjudication of the employee's application for disability benefits. Please include details of any return to work or gradual return to work.

EMPLOYER INFORMATION

Employer	Employer #
Payroll/Benefits Contact: Name Phone Number Email *If not in the global address listing*	**Attendance and Accomodations Contact:** Name Phone Number Email *If not in the global address listing*
Signature of Payroll/Benefits Contact:	Date Signed: dd/mm/yy

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Employee's Initial Application Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYEE

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#
Address	City	Province	Postal Code
Telephone - Home	Cel	Email Address	

CLAIM INFORMATION

What is your medical condition that is/was preventing you from working?

During your absence, have you performed any other work? ❑ No ❑ Yes, describe:

When do you expect to return to work? dd/mm/yy

Is your condition work related? ❑ No ❑ Yes, provide the date you sent your application to WCB dd/mm/yy

Is your condition due to the result of a motor vehicle accident? ❑ No ❑ Yes, provide the date you sent your application to SGI dd/mm/yy

Is your condition due to the result of another type of accident? ❑ No ❑ Yes, provide details about your accident

Please provide the names of the physician(s) treating you for your medical condition.

Name of Physician	Specialty	Date last visited dd/mm/yy

OTHER INCOME

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

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

❑ Canada Pension Plan (CPP) (disability and/or retirement)
❑ Other Income (please specify)
❑ Private Insurance
❑ WCB
❑ Employment Insurance
❑ SGI

Is legal action pending against a third party? ❑ No ❑ Yes, provide the name of your lawyer

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#

INCOME DECLARATION AND REIMBURSEMENT AGREEMENT

Under your Disability Income Plan (the Plan), you are required to apply for disability benefits that you or your family members may be entitled to under other disability programs, such as workers' compensation or Canada Pension Plan benefits (Other Disability Benefits).

Other Disability Benefits and any other income you receive (Reportable Income) while on an approved disability leave offset and reduce the disability benefit payments you are entitled to receive under the Plan, which can result in an overpayment from the Plan. These overpayments must be repaid to 3sHealth Employee Benefits (3sHealth), as the Plan administrator.

In accordance with the terms of the Plan, your disability benefit payments are conditional on the following terms and conditions:

1. You will promptly apply for any Other Disability Benefits for which you or your family members are eligible to apply. 3sHealth, as Plan Administrator, may require you to reapply or appeal decisions refusing your application(s) for Other Disability Benefits.
2. You will notify 3sHealth within 15 days of receiving any Other Disability Benefits or Reportable Income and disclose the amount of any such payment.
3. Upon receiving your notice, 3sHealth will determine whether the receipt of the Other Disability Benefits or Reportable Income resulted in an overpayment to you under the Plan and, if so, notify you of the amount of the overpayment (Overpayment Amount) and a schedule for repayment.
4. You must repay the Overpayment Amount to 3sHealth within the time frame established by 3sHealth in its sole discretion.
5. Failure to repay the Overpayment Amount or to report the receipt of Other Disability Benefits or Reportable Income constitutes a debt owing to 3sHealth, as administrator of the Plan, for the Overpayment Amount.

3sHealth will take all necessary steps to recover the Overpayment Amount, including withholding from benefits payable under the Plan or commencing legal proceedings.

Your signature below acknowledges that you agree to the above terms and conditions.

DIRECT DEPOSIT INFORMATION

Please provide the information for the bank account you wish your disability benefit payments to be deposited to. Please attach a void personal cheque or an encoded deposit slip for your bank account.

PLEASE ATTACH A PERSONAL CHEQUE MARKED "VOID" OR AN ENCODED BANK DEPOSIT SLIP

CERTIFICATION, STATEMENT OF ACCEPTANCE AND AUTHORIZATION

I hereby certify that the 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.

I have read, understood and accept the terms and conditions of my disability benefit payments under the Plan. I acknowledge that any Overpayment Amounts constitute a debt owing by me to 3sHealth, as administrator of the Plan.

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.

Plan member signature:	Date Signed: dd/mm/yy

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Disability Income Plan – Integrated Earnings Report

TO BE COMPLETED BY EMPLOYER

EMPLOYER CONTACT INFORMATION

Employer #	Contact	Phone #

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#

EARNINGS INFORMATION

Pay period:	Total $ amount paid for hours worked: (integrated earnings, shift differential)	Total $ amount paid for other: (stat off, vacation, sick, other)

Total $ amount paid as lump sum:

(**vacation:** ❑ Initial ❑ Subsequent)	(**earned-time off:** ❑ Initial ❑ Subsequent)	(**stat:** ❑ Initial ❑ Subsequent)

ADDITIONAL COMMENTS

- Please provide any additional information about the reported earnings.

Email reports by 11 a.m. every Tuesday. For weeks with a Monday stat holiday, reports are due by 11 a.m. Wednesday.

Please send completed reports to: ebp@3shealth.ca

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Claim Closure Form Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYER

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#
Position:		Employer #:	

REASON FOR CLAIM CLOSURE

❑ Maternity Leave	❑ Retirement	❑ Death	❑ Return to Work

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

If the employee has multiple positions please provide the return to work date and scheduled days for each position

❑ Position	❑ Return to Work date dd/mm/yy
Please check scheduled days in the week of the return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat	
❑ Position	❑ Return to Work date dd/mm/yy
Please check scheduled days in the week of the return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat	
❑ Position	❑ Return to Work date dd/mm/yy
Please check scheduled days in the week of the return to work ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat	

Please provide any additional information about the return to work:

Signature of Payroll/Benefits Contact:	Date Signed: dd/mm/yy

For 3sHealth use only

DISABILITY INCOME PLAN INFORMATION

Closure Type	Closure Date dd/mm/yy
Notes:	