3sHealth – Employee Benefits
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3sHealth
better together

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 dd/mm/yy	❑ Retirement dd/mm/yy	❑ Death dd/mm/yy	❑ Return to Work dd/mm/yy

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
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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:	