BLUE CROSS® CANASSURANCE

Employer's Statement

IDENTIFICATION

Name of Employee: _____

Policy No: _____ Social Insurance No: _____

EMPLOYEE INFORMATION

1. Employee's date of hire: _____
2. Employee's status ❑ permanent ❑ temporary ❑ seasonal ❑ part-time ❑ contractual
3. Number of regular hours worked per week: _____
4. Seasonal employees – number of weeks per year: Check months normally worked:
   ❑ January ❑ February ❑ March ❑ April ❑ May ❑ June ❑ July ❑ August ❑ September ❑ October ❑ November ❑ December
5. Gross salary: $ _____ Pay periods per year: ❑ 52 ❑ 26 ❑ 24 ❑ 12
   CPP/QPP contribution: $ _____ CEIC contribution: $ _____ QPIP contribution: $ _____
   Federal income tax: $ _____ Provincial income tax: $ _____
6. Employee position title: _____
7. Number of years in this position? _____
8. Briefly describe this employee's responsibilities: _____
   _____
9. Is this employee covered under a group or personal insurance plan to which the company subscribes or contributes?
   ❑ yes ❑ no If yes, please provide the following information:
   Name of Insurer: _____
   Group No (if applicable): _____ Certificate or Policy No: _____
10. Do you pay a portion of the Blue Cross personal insurance premium? ❑ yes ❑ no

SICK LEAVE INFORMATION

1. Date of last day worked by employee: _____ day / month / year
2. Date of last day paid by employer: _____ day / month / year
3. On the date of onset of disability, was the employee: on holiday, laid off, unpaid leave or disciplinary suspension?
   ❑ yes ❑ no If yes, please specify: _____
   _____
4. Have the responsibilities of this employee been modified recently? ❑ yes ❑ no
   If yes, please specify: _____
   _____
5. Had you noticed any change in employee performance or attendance prior to the onset of disability? ❑ yes ❑ no
   If yes, please specify: _____
6. Was the disability caused by an accident in the workplace or occupational illness? ❑ yes ❑ no
   If yes, has the employee presented a claim to CSST, WSIB or other workmen's compensation board? ❑ yes ❑ no
   If yes, please attach a copy of the claim and any related correspondence with the organization(s).
7. If necessary, could you offer: a) a gradual return to work? ❑ yes ❑ no b) lighter duties? ❑ yes ❑ no
8. Expected date of return to work: _____ day / month / year
9. If employee has already returned to work, please specify date: _____ day / month / year
10. Do you have any doubts about the validity of this claim? ❑ yes ❑ no

IMPORTANT: PLEASE COMPLETE REVERSE OF THIS FORM

WORKING ENVIRONMENT INFORMATION – Is this employee exposed to one or other of the following? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Noise							
Dust							
Vibration							
Outdoor work							
Hazardous machinery							
Hazardous products							
Other (Please specify) _____							

PHYSICAL EFFORT INFORMATION – To what extent must this employee do as follows? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Position							
Sit							
Stand							
Walk							
Crouch on knees							
Crawl							
Stretch arms above shoulder height							
Stretch arms below shoulder height							
Climb up and down stairs							
Effort							
Lift up							
Push							
Raise							
Pull							
Move objects							
Conduct repetitive movements							

Can this employee change position if needed? ❑ yes ❑ no

Percentage of time per day: sitting: _____ % standing: _____ % walking: _____ %

Is this employee required to lift heavy objects? ❑ yes ❑ no

Maximum weight is normally:

❑ 0 - 5 ❑ 10 - 15 ❑ 20 - 25 ❑ 30 - 35 ❑ 40 - 45 ❑ 50 and over (❑ pounds or ❑ kilograms)

If this employee's work involves repetitive movement, please specify: _____

Percentage of total working time: _____ %

Limb(s) solicited: _____

_____

Repetitive movement with: ❑ dexterity (e.g.: keyboard speed) or ❑ physical effort (e.g.: assembly line)

Pace is: ❑ fixed (e.g.: feed machine) or ❑ variable

PSYCHOLOGICAL EFFORT DETAILS – To what extent must this employee resort to? (check as applicable):

	Rarely	Not often	Often	Very often	Constantly	Never	n/a
Memory and comprehension							
Sustained concentration							
Social interaction							
Adaptation							

STATEMENT

I hereby certify that the information provided hereinabove is, to the best of my knowledge, true and complete.

Name of company: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____ E-mail: _____

Name of signatory: _____ Title: _____

Signature: _____ Date: _____ day / month / year