SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

APPLICATION FOR BENEFITS
EMPLOYER STATEMENT

Group Name

Policy Number

- ☐ Short Term Disability (Weekly Indemnity)
- ☐ Long Term Disability
- ☐ Waiver of Premium

PLAN MEMBER INFORMATION

Last Name | First Name | Initial

Sex: ☐ Male ☐ Female ☐ Unspecified

Date of Hire (YYYY/MM/DD) | Effective date of coverage (YYYY/MM/DD) | Date last worked (YYYY/MM/DD)

Occupation on date last worked

Complete and attach Job Description form before submitting this document.

Are you holding the plan member's job for him/her? ☐ Yes ☐ No

Are there any other jobs in your organization that the plan member may be qualified to do? ☐ Yes ☐ No

Describe:

PLAN MEMBER INJURY & ABSENCE

Is the plan member's condition due, or related, to occupational illness or accident (past or present)? ☐ Yes ☐ No
If yes, attach copy of provincial Workers' Compensation correspondence.

Has the plan member ever submitted an application for similar cause(s)? ☐ Yes ☐ No
If yes, complete fields below:

From: _____ To: _____ Insurance Carrier: _____
YYYY MM DD YYYY MM DD

Indicate the number of days that he/she was absent from work due to illness.

During the past year: _____ Average in previous years: _____

Indicate type of income during absence (salary continuation, paid sick leave, paid vacation, other) and dates covered:

Type of income: _____ From: _____ (YYYY/MM/DD) To: _____ (YYYY/MM/DD)

Type of income: _____ From: _____ (YYYY/MM/DD) To: _____ (YYYY/MM/DD)

PLAN MEMBER INCOME

Regular Gross Monthly Earnings:

- ☐ Weekly $ _____
- ☐ Yearly $ _____
- ☐ Commission Based - attach T4 from previous two years

Effective date of last salary change (YYYY/MM/DD):

Additional information that may be of value in the consideration of this claim:

PLAN SPONSOR INFORMATION

I hereby declare that the answers to the above questions are accurate and complete.

Contact Name: _____
Last First Initial Title

Telephone Number | Fax Number | Email Address

Signature | Date (YYYY/MM/DD)