SHEPP
SASKATCHEWAN HEALTHCARE EMPLOYEES' PENSION PLAN

201 - 4581 Parliament Ave.
Regina, SK S4W 0G3
Phone 306.751.8300
Toll-Free 1.866.394.4440
Fax 306.751.8301
E-mail sheppinfo@shepp.ca
Website www.shepp.ca

Employer's Statement of Disability

FOR OFFICE USE ONLY: 039 CASE ID: _____

1 Personal Information

Member Information

Name First Name _____ Middle Name _____ Last Name _____ Member ID # _____

Date of Birth (dd/mm/yyyy) _____ Gender: ☐ Female ☐ Male

Address & Contact Information

Address _____ City _____

Province _____ Postal Code _____ Country _____ Phone (###)###-#### _____ E-mail _____

Affliation

☐ Saskatchewan Union of Nurses (SUN)
☐ Service Employees International Union (SEIU)
☐ Canadian Union of Public Employees (CUPE)
☐ Out of Scope
☐ Other Union _____

☐ 3sHealth/Saskatchewan Union of Nurses (SUN)
☐ 3sHealth/Service Employees International Union (SEIU)
☐ 3sHealth/Canadian Union of Public Employees (CUPE)
☐ 3sHealth/General ☐ PEBA ☐ SGEU
☐ Other _____

2 Claim Details

Is this a work-related disability? ☐ No ☐ Yes, date Workers' Compensation Board application submitted (dd/mm/yyyy) _____

Is this a pregnancy-related disability? ☐ No ☐ Yes, date maternity leave will start (dd/mm/yyyy) _____

3 Employment Details

Member is ☐ Full-time ☐ Part-time ☐ Casual

Position is classified as ☐ Permanent ☐ Temporary Regular Earnings _____ per hour

Day member last worked (dd/mm/yyyy) _____ Sick leave earned at date of disability _____ days _____ hours

Sick leave expiry date (dd/mm/yyyy) _____ Date member has been/will be paid to (dd/mm/yyyy) _____

Please check scheduled days in final payment week ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Has member returned to work ☐ No ☐ Yes, return to work date (dd/mm/yyyy) _____

Please check scheduled days in return to work week ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Number of hours in a regular work week _____ Average number of hours in a regular work day _____

Date employment began (dd/mm/yyyy) _____ Has employment been terminated? ☐ No ☐ Yes, date (dd/mm/yyyy) _____

Is the member other than full-time (OTFT) ☐ No ☐ Yes, provide the total regular paid hours in the 52 weeks immediately preceding the member's last day of work: _____ hours Number of weeks the member was paid in the above period: _____ weeks

List any and all periods of unpaid leave:

Is the member receiving WCB net pay top-up benefits? ☐ No ☐ Yes, from (dd/mm/yyyy) _____ to (dd/mm/yyyy) _____

Instructions: o Submit this form to SHEPP o Keep a copy for your files

3 Employment Details (continued)

Note: Please attach a copy of the member's current job description to this form.

Provide any comments which may help us to process the member's application for pension accrual while disabled.

4 Authorisation

Employer Authorisation

Contact Name _____ Title _____

Phone (###)###-#### Fax (###)###-#### E-mail _____

_____ Date (dd/mm/yyyy)

Contact Signature

Instructions: o Submit this form to SHEPP o Keep a copy for your files