Employer's Statement of Disability

SHEPP
People. Pensions. Results.

FORM ID: 039 CASE ID: _____

1 Personal Information

Member Information

First Name _____ Middle _____ Last Name _____

Date of Birth (dd/mm/yyyy) _____ Gender: ◯ Female ◯ Male Member ID# _____

Address and Contact Information

Address _____ City _____ Province _____

Country _____ Postal Code _____ Phone _____ Email _____

Affiliation

◯ 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

Instructions

✓ **Submit this form to SHEPP**

✓ **Keep a copy for your files**

SHEPP recognizes and respects the importance of your privacy. Personal information collected is used for the purpose of administering your benefits under the Plan.

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Toll Free: 1.866.394.4440
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sheppinfo@shepp.ca
www.shepp.ca

3 Employment Details (continued)

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) _____

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 Authorization

Employer Authorization

Contact Name _____ Title _____

Phone _____ Fax _____ Email _____

_____ _____

Contact Signature Date (dd/mm/yyyy)