Member's Application for Pension Accrual While Disabled

SHEPP
People. Pensions. Results.

1 Personal Information

FORM ID: 022 CASE ID: _____

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 _____

Postal Code _____ Country _____ Phone _____ Email _____

2 Claim Details

Describe the nature of your disability _____

Describe the limitations that result from your disability

Date you were first unable to work due to your disability (dd/mm/yyyy) _____

Physician(s) treating your disability:

Name of Physician _____ Specialty _____

Date (dd/mm/yyyy) _____ Reason _____

Name of Physician _____ Specialty _____

Date (dd/mm/yyyy) _____ Reason _____

Name of Physician _____ Specialty _____

Date (dd/mm/yyyy) _____ Reason _____

Have you been treated for the same disability before? ◯ No ◯ Yes If yes please list the physician who treated you:

Name of Physician _____ Specialty _____

Date (dd/mm/yyyy) _____ Reason _____

Is your disability caused wholly or in part by any of the following:

Pregnancy ☐ No ☐ Yes

Date maternity leave will start (dd/mm/yyyy) _____

Work duties/responsibilities ☐ No ☐ Yes

Date Worker's Compensation Board application submitted (dd/mm/yyyy) _____

Motor vehicle accident ☐ No ☐ Yes

Date SGI application submitted (dd/mm/yyyy) _____

Other accident ☐ No ☐ Yes

Are you a member of a short or long term disability plan of your employer? ☐ No ☐ Yes

Name of disability plan _____

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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Phone: 306.751.8300
Toll Free: 1.866.394.4440
Fax: 306.751.8301

sheppinfo@shepp.ca
www.shepp.ca

3 Employment Details

Since your last day worked for your SHEPP employer, have you participated in any employment activities? (e.g. home business, farming, spouse's business)

☐ No ☐ Yes, describe:

When do you expect to return to work with your SHEPP employer?

Describe the responsibilities and duties of your job which your disability prevents you from performing:

Describe your present typical daily activities:

4 Authorization

Member Declaration

I hereby certify that the above answers are full and true to the best of my knowledge and belief. I authorize my physician or healthcare practitioner to provide the Saskatchewan Healthcare Employees' Pension Plan with any information requested in connection with this claim. A photocopy of this authorization shall be valid.

Note: Failure to complete this form in its entirety may result in the form being returned to you, delaying the evaluation of your application.

Employee Signature

Date (dd/mm/yyyy)