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

Member's Application for Pension Accrual While Disabled

FOR OFFICE USE ONLY: 022 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 _____

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

3 Employment Details

Since your last day worked for you 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 Authorisation

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 authorisation 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) _____

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