Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Employer Statement of Absence for Short Term Disability (STD) Benefit Coverage

Send to:
Email: luene@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

1) Company Information - this form cannot be filled out by the Employee applying for STD Benefit coverage

Company Name:	**Policy Number:**
Signed By:	**Date Completed: (mm/dd/yyyy)**

2) Designated Company Representative (Primary Contact for Claims)

Last Name:	First Name:		Job Position/Title:
Work Phone:	Extension:	Email:	Fax:

3) Alternate Company Contact

Last Name:	First Name:		Job Position/Title:
Work Phone:	Extension:	Email:	Fax:

4) Employee Information

Last Name:	First Name:	Date of Birth: (mm/dd/yyyy)	Employee Number:
Home Address:	City:	Province:	Postal Code:
Home Phone:	Work Phone and Extension:		
Job Position/Title:	Date of Hire: (mm/dd/yyyy)	Social Insurance Number:	
Date of Eligibility to Insurance Plan: (mm/dd/yyyy)	Date Employee Joined the Plan: (mm/dd/yyyy)		

5) Rate of Pay

Employee Status:	Pay Rate:	Per:

Please provide the employee's standard work schedule
(Number of hours worked per day)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Has the employee applied for disability benefits with any other company?
If so, please indicate below:

Company:			
Type of Insurance:			
Amount of Benefits:	Per:		
Benefits Taxable?	◯ Yes	◯ No	◯ Not Specified
Coverage Over and Above the Non-Evident Maximum?	◯ Yes	◯ No	◯ Not Specified

Indicate which benefits are applied for, are receiving, or expect to receive from any of the following sources:

☐ Canada or Quebec Pension Plan Disability Benefit * *Important Note: Please attach a copy of the "Notice of Entitlement" or "Decline" Letter.	$	☐ Retirement Pension Plan	$
☐ Automobile Insurance	$	☐ Employment Insurance Commission	$
☐ Worker's Compensation Board	$	☐ Other	$

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6) Work Requirements

Description of Work Environment:

Legend:	**Occasionally:** Less than 33% of the day	**Frequently:** 34% to 66% of the day	**Constantly:** More than 67% of the day

Physical Demands	**N/A**	**Occasionally**	**Frequently**	**Constantly**
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Lifting & Carrying	☐	☐	☐	☐
Average Weight:	☐ Lbs	☐ Kgs		
Climbing Stairs	☐	☐	☐	☐
Repetitive Movements	☐	☐	☐	☐
Overhead Movements	☐	☐	☐	☐
Below Waist Movements	☐	☐	☐	☐
Hot Environment Exposure	☐	☐	☐	☐
Cold Environment Exposure	☐	☐	☐	☐
Typing / Use of Mouse	☐	☐	☐	☐
Communication with External Clients	☐	☐	☐	☐
Follows Detailed Instructions	☐	☐	☐	☐
Need for Constant Concentration	☐	☐	☐	☐
Complex Decision Making	☐	☐	☐	☐
Uses Public Transportation	☐	☐	☐	☐
Travels By Car	☐	☐	☐	☐

7) Information Concerning the Absence

1st Day of Absence: (mm/dd/yyyy)	Absence Type: ◯ STD ◯ LTD	1st Day of Benefit Coverage: (mm/dd/yyyy)

Duration of the Plan Benefits: ◯ 17 weeks ◯ 26 weeks Other:

Type of Claim: ◯ Accident ◯ Illness ◯ Hospitalization

Did the Illness/Injury occur while the Employee was on vacation? ◯ Yes ◯ No ◯ Not Specified

Scheduled date of return from vacation: (mm/dd/yyyy)

To the best of your knowledge, are there any performance or employment issues, work changes, conflicts or concerns with absenteeism? ◯ Yes* ◯ No ◯ Not Specified

* If Yes, please specify:

8) Return to Work Status

Has the Employee returned to work? ◯ Yes ◯ No ◯ Not Specified

* If Yes, Date Returned: (mm/dd/yyyy)

* If Yes, what type and frequency of work? ◯ Full Time ◯ Part Time

* If Modified, specify:

9) Availability for Modified Work

To facilitate early return to the workplace, which of the following can be accommodated?

☐ Progressive Return to Work
☐ Contact Restriction with External Clients
☐ Sitting Limitation
☐ Standing Limitation
☐ Lifting and Carrying Limitation
☐ Over the Shoulder Lifting Limitation
☐ Repetitive Movement Limitation

10) Comments

Comments:

11) Important Information

Please provide the employee with the medical forms to be completed.