SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

To complete your claim submission:

- Complete the Plan Member's Statement
- Complete Part 1 on the Physician's Initial Report and have your healthcare provider complete the remaining parts
- Have your employer complete the Plan Member's Job Demands form
- Submit the Plan Member's Statement, Physician's Initial Report, Release Forms, and Banking Information to the SGEU LTD Plan

☐ I certify the information given on this claim form is true, correct, and complete to the best of my knowledge.

Part 1 – Member Information

MEMBER IDENTIFICATION (Please Print)

Last Name:	**First Name:**	**Middle Initial:**

Gender: Female ☐ Male ☐ Other ☐	**Date of Birth (mm/dd/yy):** Include government issued Identification (i.e Driver's License or Passport)	**Social Insurance Number:**

Address:	**City/Town:**	**Province:**	**Postal Code:**

Cell:	**Home:**	**Home Email Address:**

Employer:	**Job Title:**

Part 2 – Claim Information

When was your last physical day at the workplace: (mm/dd/yy) _____
(if date unknown, contact your employer)
IMPORTANT: do not include sick leave or vacation days taken after this date

Indicate if you have tried to return to work? ☐ No ☐ Yes

If Yes, Give dates: From: _____ (mm/dd/yy) To: _____ (mm/dd/yy)

I returned to (select all that apply): ☐ Regular duties and hours ☐ Modified duties ☐ Modified hours ☐ New Job

If no, when to you expect to return (if known): _____ (mm/dd/yy)

Are there any aspects of your job that you might be able to do, even on a reduced basis? If yes, describe:

During your absence, have you performed any other work? ☐ No ☐ Yes. If yes, describe:

What is/was the medical condition causing your absence from work? Describe your present condition, the cause (if known), and the history to date. (Attach additional if more space is needed)

☐ I have attached additional information.

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

Is your condition work-related? ☐ No ☐ Yes. If yes, have you submitted a WCB claim? ☐ No ☐ Yes
If yes, provide your Workers' Compensation claim number:

Is your condition the result of a motor vehicle accident (MVA)? ☐ No ☐ Yes. If yes, have you submitted an SGI (MVA) claim? ☐ No ☐ Yes **If yes,** when and where did the accident occur (mm/dd/yy):
Provide details about the accident:

Part 3 – Treatment Information

Were you admitted to a hospital? ☐ No ☐ Yes. If yes, provide the date(s) and hospital name(s).

Hospital name:

Date admitted (mm/dd/yy):	**Date discharged (mm/dd/yy)**	**Or** ☐ Still hospitalized

Have you had surgery since being off work, or is surgery planned: ☐ No ☐ Yes.

Date of surgery (mm/dd/yy):	**Type of surgery:**

Other treatment (crutches, physiotherapy, medication, counseling.):

Primary healthcare provider

Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):

Do you have other healthcare providers related to this claim? ☐ No ☐ Yes. **If yes,** please provide details.

Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):
Provider's name:	**Specialty:**
Office Location: (City, Province)	
Phone number:	Date first seen this provider (mm/dd/yy):

If more space is needed, please attach. ☐ I have attached additional information.

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits
Plan Member's Statement

Part 4 – Education, Training, Experience

ATTACH RESUME OR COMPLETE THE FOLLOWING

EDUCATION

Highest level of education completed:

School Name	Location: Level Obtained:	Year (yyyy):	Area of Study & Years Completed

WORK EXPERIENCE

Duration of Employment		Employer	Job Title
From (mm/dd/yy)	To (mm/dd/yy)		

Please attach a separate sheet if additional space is required

Part 5 – Disability Income

Please answer no or yes to each question below and provide details and additional documents as appropriate:

1. Are you receiving **Canada Pension Plan (CPP)** ***Retirement*** Income? ☐No ☐Yes
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)
☐ provide a copy of your approval letter.

2. Have you applied for CPP *Retirement* Income, but have not yet been accepted? ☐No ☐Yes

3. Are you receiving **Canada Pension Plan (CPP)** ***Disability*** Income? ☐No ☐Yes
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)
☐ provide a copy of your approval letter.

4. Have you applied for CPP *Disability* Income, but have not been accepted? ☐No ☐Yes
If yes, please indicate: ☐ My claim decision is pending, **or** ☐ My claim has been declined*

Date of Decline: _____ (mm/dd/yy) Date of Appeal:_____ (mm/dd/yy)

5. Are you receiving **Workers Compensation Board** ***(WCB)*** or **Saskatchewan Government Insurance** ***(SGI)*** Income?
☐ No ☐Yes (WCB) ☐Yes (SGI)
If yes, what is the monthly benefit amount: _____ Date payments began: _____ (mm/dd/yy)

6. Have you applied for WCB or SGI Income benefits, but have not been accepted?
☐No ☐Yes (WCB) ☐Yes (SGI)
If yes, please indicate: ☐ My claim decision is pending, or ☐ My claim has been declined

Date of Decline: _____ (mm/dd/yy) Date of Appeal:_____ (mm/dd/yy)

SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
1-800-667-5221
LTD@SGEU.ORG

Claim for SGEU Long Term Disability Benefits Plan Member's Statement

7. Are you receiving **any other income**? ☐No ☐Yes

If yes: Source (eg. Other Insurer, Other employer, Self-employed, Retirement) _____

Monthly Amount: _____ Dates of Payments: From _____ (mm/dd/yy)

Part 6 – Authorization, Declaration, and Reimbursement Agreement

I understand and agree that:

- I may be required to apply for other disability/pension benefits (WCB/SGI/CPP Disability/Pension) that I may be entitled to receive because of my disability and that I may be asked by SGEU LTD or its third-party medical adjudicator to reapply or appeal decisions refusing my application(s) if considered applicable.
- During the time it takes for my application for these other benefits to be accepted, or my entitlement to any other reportable income to be reviewed, SGEU LTD through it's third-party medical adjudicator, may continue paying me amounts equivalent to the disability benefits payments under the SGEU Plan Text. The terms "other benefits" and "other reportable income" refer to any of the types of disability benefits and other income mentioned under the SGEU LTD Plan Article 8.3 "Income From Other Sources".
- If I am entitled to receive any other disability benefits or other reportable income, this may result in an overpayment that I will be required to pay back to the SGEU LTD Plan.
- SGEU LTD may reduce my disability benefit payments by the amount of other disability/pension benefits or other reportable income that I receive or become entitled to.

I agree to:

- Notify SGEU LTD or its third-party medical adjudicator within 15 days of receipt of any other reportable income (including any other disability benefit/pension payments) or any other reportable Income.
- Repay SGEU LTD within the time frame SGEU LTD or its third-party medical adjudicator advises me of after I am notified of the overpayment or within a longer period if SGEU LTD agrees in writing. I understand that if the overpayment is not reported when due, SGEU LTD and its third-party medical adjudicator may take all necessary steps to recover the overpayment, including withholding the payment, or recovering the overpayment from any benefits under the SGEU LTD Plan.

Declaration:

☐ I declare the information I have entered is accurate and factual. I understand and agree to the terms under the income declaration and reimbursement section.

I authorize the use of my Social Insurance Number for the administration of my benefits. I hereby authorize the use of all information in my file for the purposes of adjudication and administration of my long-term disability claim, as per the SGEU LTD Plan Text. A photocopy of this authorization shall be as valid as the original.

Dated at _____ this _____ Month _____ Day of _____ Year.

Your name (please print): Signature:

_____ _____

Please attach copies of any correspondence or documentation relating to other income including WCB, SGI or CPP Notice of Entitlement or CPP Payment Explanation Statement, approval or denial letters, and notices of appeal.

Mail:
Attention: SGEU Disability Management Services
1011 Devonshire Drive North
Regina, SK. S4X 2X4

Fax:
1-306-775-5775
Email:
LTD@SGEU.ORG