Short Term Disability (STD) Benefits- Statement of Claim

MANION

SECTION 1 - TO BE COMPLETED BY THE EMPLOYEE ***(please print)***

EMPLOYEE'S NAME (Last)	(First)		
ADDRESS (Number, Street, City, Province)		POSTAL CODE	EMPLOYEE ID NUMBER
PHONE NUMBER	DATE OF BIRTH	EMAIL ADDRESS	GROUP PLAN #

1. On what date were you first disabled and unable to work? Day / Month / Year ____ Time ____ a.m. / p.m.
2. On what date do you expect to return to work? Day / Month / Year ____
3. Is disability due to an accident? ☐ NO ☐ YES
   If "YES" please answer the following questions:
   a) When did it happen? Day / Month / Year ____ Time ____ a.m. / p.m.
   b) Where did it happen? ☐ at home ☐ at work ☐ elsewhere (name place) _____
   c) How did it happen? _____
4. On what date were you first treated by a physician for this disability? Day / Month / Year ____
5. List names and addresses of physicians who have treated you in connection with this disability.

   _____ _____

   _____ _____
6. Have you been hospitalized in connection with this disability? ☐ NO ☐ YES If "YES" please indicate:
   Name of hospital: _____
   Dates hospitalized: FROM Day / Month / Year ____ TO Day / Month / Year ____
7. Are disability benefits payable from any other source as the result of this sickness or injury? ☐ NO ☐ YES
   If "YES" give name of source: _____
8. I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that

   Manion, Wilkins & Associates Ltd. will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize Manion Wilkins & Associates Ltd. to evaluate or investigate my claim, and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my employer, any licensed physicians or other health professionals, any medical facility, any insurance company or government body, and any other person or institution to release relevant information to Manion, Wilkins & Associates Ltd. solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

_____ _____

Employee's Signature Date

SECTION 2 - TO BE COMPLETED BY THE EMPLOYER ***(please print)***

1. On what date did the employee last work? Day / Month / Year ____ Number of hours: ____
2. What was the reason for leaving work? Check appropriate box:
   ☐ Disability ☐ Dismissed ☐ Temporary Layoff ☐ Strike ☐ Quit ☐ Retired
3. Employee's Regular Earnings: _____ ☐ Hourly ☐ Weekly ☐ Salaried
4. Occupation: _____ Date of Hire: _____
5. Call Required: ☐ Yes
6. Contact Name: _____

Signed by: _____ Title: _____ Date: _____

Performance Concerns:

Manager's Name: Manager's Phone No.:

Manager's Email:

ONCE COMPLETED, PLEASE FORWARD TO THE OFFICE OF THE ADMINISTRATOR AS INDICATED BELOW

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