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MONCTON NB E1C 8L3
TEL: 1-800-667-4511
FAX: 1-800-644-1722

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-800-667-4511
FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-800-355-9133
FAX: 416-626-0400

PO BOX 668 STATION B
MONTREAL QC H3B 3K3
TEL: 1-800-456-6595
FAX: 1-844-244-8198
salaire@medavie.bluecross.ca

Group Name: _____	<input type="checkbox"/> Salary Continuation <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waiver of Premium
Store Number/Work Location: _____	
Policy Number: _____ Division: _____	

Employee Name: _____

Last First Initial

Male Female SIN: _____ Date Last Worked: _____

YYYY MM DD

Employee's Occupation on Date Last Worked: _____
(Please complete on reverse or attach formal Job Description Form)

Is the employee's job being held for him/her? Yes No Date of Birth: _____

YYYY MM DD

Are there any other jobs in your organization that the employee may be qualified to do? Yes No Please elaborate: _____

Return to Work Date: _____

YYYY MM DD

Is the condition due or related to occupational illness or accident (past or present)? Yes No
(If yes, attach copy of WORKER'S COMPENSATION correspondence)

Has the employee ever submitted an application for similar cause(s)? Yes No If yes, include dates paid and insurance carrier:

From: _____ To: _____ Carrier: _____

YYYY MM DD YYYY MM DD

Attendance Pattern - Indicate the number of days that this employee was absent from duty due to illness:
_____ during the past year _____ average in previous years.

Please identify and indicate dates covered by: Salary Continuation, Paid Sick Leave, Paid Vacation, Other.

_____ Type of income _____ YYYY MM DD _____ Type of income _____ YYYY MM DD

Employment Start Date: _____ Employee's Effective Date of Coverage: _____

YYYY MM DD YYYY MM DD

Employee Classification: _____

Earnings as of Date Last Worked:

hourly _____ hrs/wk Commission Basis

weekly **If Commission Basis, please attach previous year's T4.**

\$ _____ monthly

yearly

income tax deducted per pay period \$ _____ , \$ _____ , \$ _____

Please include any additional information that you believe will be of value in consideration of this claim.

Group Administrator: _____

Last First Initial

Title: _____ Telephone: () _____ Fax: () _____

Signature: _____ Date: _____

YYYY MM DD

JOB DESCRIPTION

IMPORTANT: All information should pertain to the employee's regular duties immediately prior to his/her illness or injury.

Employee Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Policy No.:	Identification No.:
Job Title:	How long has the employee worked at this job?	

Is there shift work involved? Yes No Number of hours worked each week: Usual hours worked each day From _____ to _____

Job duties and activities. (List most important first)	Hours per day
1. _____ / _____	_____
2. _____ / _____	_____
3. _____ / _____	_____
4. _____ / _____	_____
5. _____ / _____	_____

MOBILITY

Activities	Yes / No	Frequency (Times per day / hours per day)	Activities	Yes / No	Frequency (Times per day / hours per day)
Sitting			Driving		
Standing			Remaining in the same position for more than one hour		
Walking			Reaching above shoulder		
Climbing			Reaching at shoulder height		
Bending / Crouching			Reaching below shoulder height		
Kneeling					

STRENGTH

Activities	Frequency					Weight		Comments
	Not Per- formed	Not Per- formed Daily	Up to 1 Hour Daily	1 - 3 Hours Daily	+ 3 Hours Daily	Usual	Max	
Lifting								
Pushing								
Pulling								
Manual Dexterity								

WORK ENVIRONMENT Please comment on the activities/environmental factors listed below as related to this occupation.

Activities	Yes	Frequency / Duration	Activities	Yes	Frequency / Duration
Inside Work	<input type="checkbox"/>		Slippery Area	<input type="checkbox"/>	
Outside Work	<input type="checkbox"/>		Tools (Sharp, hazardous)	<input type="checkbox"/>	
Temperature (Hot / cold)	<input type="checkbox"/>		Machinery (Electrical, vibratory, motorized)	<input type="checkbox"/>	
Humid / Dry	<input type="checkbox"/>		Travelling	<input type="checkbox"/>	
Dust	<input type="checkbox"/>		Work alone	<input type="checkbox"/>	
Vapour Fumes	<input type="checkbox"/>		Work in Group	<input type="checkbox"/>	
Noise (degree)	<input type="checkbox"/>		Interact with public	<input type="checkbox"/>	
Moving Objects	<input type="checkbox"/>				

Direct Supervisor's Signature: _____ Telephone: () _____

Position/Title: _____

I hereby certify that I have carefully read this job description and consider it to be a true and accurate account of my regular duties.

Employee's Signature: _____ Date: _____