THE
Great-West Life
ASSURANCE COMPANY

Application for Group Short Term Disability Benefits - Employer's Statement

Completed Employer and Employee Statements are required before disability claim assessment can commence. Please complete this Employer's Statement in its entirety and then send the completed form to OASSIS. Please have the completed Employer Statement sent via email: michelle@oassisplan.com or via fax: 647-689-3061.

Upon receipt of this completed Statement, OASSIS will send Great-West Life the completed Employer Statement. Upon receipt of this form, Great-West Life will set up a disability file and will follow up with the employee for the completed Employee Statement. The Employee Statement should be submitted directly to Great-West Life, as per the instructions noted on the Employee Statement. Please do not submit Employee Statements to OASSIS.

Claims will be reviewed once all forms (Employer, Employee and Attending Physician Statement) have been received by Great-West Life.

Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee.

A. IDENTIFICATION

Plan Sponsor Name		Plan Number	Division Number (if applicable)	Class (if applicable)
OASSIS		**169021**		
Address: Street & Number	PO Box	City	Province	Postal code
5409 Eglinton Ave W, Suite 208		**Toronto**	**ON**	**M9C 5K6**

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth

Address: Street & Number	PO Box	City	Province	Postal Code

Telephone Number	Cell Number	Fax Number

C. EMPLOYMENT INFORMATION

Date last worked MM/DD/YY ________________ Number of hours ________

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Work related accident or sickness
☐ Quit ☐ Retired ☐ Other ☐ Temporary Lay-off ☐ Paid Vacation

Is the employee: ☐ Full time: Number of hours worked per week ____________ ☐ Part time: Number of hours worked per week ____________

Is the employee: ☐ Permanent ☐ Temporary ☐ Contract

Is the employee: ☐ Hourly ☐ Salaried

Please submit copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If no, is a return to work date known?	Has employment terminated?
☐ Yes ________________ MM/DD/YY ☐ No	☐ Yes ________________ MM/ADD/YY ☐ No	☐ Yes ________________ MM/DD/YY ☐ No

- During the period of disability, have you made any payments to this employee? ☐ Yes ☐ No
- If yes, specify the nature, the period, and the amount of any such payments (E.g.: Vacation, sick leave)

____

D. EARNINGS AND BENEFIT INFORMATION

Please answer the following questions. If any do not apply, put N/A in the blank.

Employee's Gross monthly earnings	TD-1 Federal personal tax credits:	Date earnings ceased or will cease: MM/DD/YY	According to your records: Basic LTD Benefit Amount:
$ ________________ per month			

Is the employee covered for Group Life Insurance?	Is the employee covered for Optional Life Insurance?
☑ Yes 169021 Plan number $ ____________ Amount ☐ No	☐ Yes 169022 Plan number $ ____________ Amount ☐ No

Has it been determined that the employee's earnings are tax exempt under the Indian Act (CRA form TD1-1N)? ☐ Yes ☐ No

If yes, percentage of employment income that is tax exempt: ________________ %

If the employee has Optional Life Insurance, please submit a copy of the Optional Life approval letter.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Name (please print): ________________________________ Date: ________________

Title: ________________________________ Phone: ________________

Email address: ________________________________ Fax: ________________

Authorized Signature: ________________________________

If submitting form by fax or mail, the **Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.

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F. JOB INFORMATION

Employee's job title as of last day worked	How long has the employee worked in this position? Years ___ Months ___

COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER. If you have a prepared job description, please submit it.

What are the duties in this job, and what percentage of time does each take per week?

Duties	Percentage of time per week

To ensure proper management of this claim, more detailed job information may be requested at a later date.

When did the employee's disability first appear to affect his/her work? (MM/DD/YY)	In what ways did performance on the job change as a result of the disability?

Were any changes made in the employee's job duties as a result of the disability? ☐ Yes ☐ No
If yes, please explain what the changes were and when they were made:

If the employee could return to part-time or less demanding work, would such work be available? ☐ Yes ☐ No
If no, please explain.

ADDITIONAL INFORMATION

Please provide any additional information that you believe should be considered in assessing this employee's claim.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Name (please print): ____________________ Date: ____________

Title: ____________________ Phone: ____________

Email address: ____________________ Fax: ____________

Supervisor or Authorized Signature: ____________________

If submitting form by fax or mail, the **Supervisor or Authorized Signature** field must be signed.
If submitting form online, online certification will be applied.