

Employee's Initial Application Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYEE

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth	dd/mm/yy	Benefit ID#
Mailing Address		City	Province	Postal Code
Telephone - Home	Cell	Email Address		

CLAIM INFORMATION

What is your medical condition that is/was preventing you from working?

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

When do you expect to return to work? dd/mm/yy

Is your condition work related? ☐ No ☐ Yes, provide the date you sent your application to WCB dd/mm/yy

Is your condition due to the result of a motor vehicle accident? ☐ No ☐ Yes, provide the date you sent your application to SGI dd/mm/yy

Is your condition due to the result of another type of accident? ☐ No ☐ Yes, provide details about your accident

Please provide the names of the physician(s) or nurse practitioner treating you for your medical condition.

Name of Physician/Nurse Practitioner	Specialty	Date last visited	dd/mm/yy

OTHER INCOME

Have you received income from any of the sources listed below during your absence from work? ☐ No ☐ Yes

If yes, please check the appropriate box and note that you must provide with this form a copy of correspondence that states the type of income or benefit you received, the amount you received, and the date you received the income or benefit, if you have not already submitted this information to 3sHealth.

☐ Canada Pension Plan (CPP) (disability and/or retirement)
 ☐ Other Income (please specify)

☐ Private Insurance
 ☐ WCB

☐ Employment Insurance
 ☐ SGI

Is legal action pending against a third party? ☐ No ☐ Yes, provide the name of your lawyer

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First Name

Last Name

Date of Birth

dd/mm/yy

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INCOME DECLARATION AND REIMBURSEMENT AGREEMENT

Under your Disability Income Plan (the Plan), you are required to apply for disability benefits that you or your family members may be entitled to under other disability programs, such as workers' compensation or Canada Pension Plan benefits (Other Disability Benefits).

Other Disability Benefits and any other income you receive (Reportable Income) while on an approved disability leave offset and reduce the disability benefit payments you are entitled to receive under the Plan, which can result in an overpayment from the Plan. These overpayments must be repaid to 3sHealth Employee Benefits (3sHealth), as the Plan administrator.

In accordance with the terms of the Plan, your disability benefit payments are conditional on the following terms and conditions:

1. You will promptly apply for any Other Disability Benefits for which you or your family members are eligible to apply. 3sHealth, as Plan Administrator, may require you to reapply or appeal decisions refusing your application(s) for Other Disability Benefits.
2. You will notify 3sHealth within 15 days of receiving any Other Disability Benefits or Reportable Income and disclose the amount of any such payment.
3. Upon receiving your notice, 3sHealth will determine whether the receipt of the Other Disability Benefits or Reportable Income resulted in an overpayment to you under the Plan and, if so, notify you of the amount of the overpayment (Overpayment Amount) and a schedule for repayment.
4. You must repay the Overpayment Amount to 3sHealth within the time frame established by 3sHealth in its sole discretion.
5. Failure to repay the Overpayment Amount or to report the receipt of Other Disability Benefits or Reportable Income constitutes a debt owing to 3sHealth, as administrator of the Plan, for the Overpayment Amount.

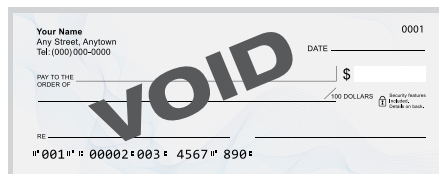
3sHealth will take all necessary steps to recover the Overpayment Amount, including withholding from benefits payable under the Plan or commencing legal proceedings.

Your signature below acknowledges that you agree to the above terms and conditions.

DIRECT DEPOSIT INFORMATION

Please provide the information for the bank account you wish your disability benefit payments to be deposited to. Please attach a void personal cheque or an encoded deposit slip for your bank account.

Note: Disability benefits are only paid by direct deposit to your bank or other financial institution.



CERTIFICATION, STATEMENT OF ACCEPTANCE AND AUTHORIZATION

I certify that the information provided in support of my claim is full and accurate to the best of my knowledge. I understand that any misrepresentation or omission may result in the denial or termination of benefits. I have read, understood, and agree to the terms of the applicable disability benefit plan.

I authorize Health Shared Services Saskatchewan ("3sHealth") and its designated representatives to collect, use, and disclose my personal information, including personal health information (my "information"), as is reasonably necessary to assess, adjudicate, administer, manage, or terminate my disability claim. This includes determining eligibility, facilitating benefit payments, supporting rehabilitation and return to work, recovering overpayments, meeting legal requirements, and the use of my Social Insurance Number for tax reporting (as required).

I authorize any government agency, insurer, reinsurer, employer or plan sponsor, physician, healthcare practitioner, facility, or other organization that is involved in my care to disclose to 3sHealth any of my information required for the purposes above. I authorize 3sHealth to disclose my information to third-party service providers, including medical assessors and data processing vendors, using only the minimum information necessary for those purposes. I authorize disclosure of my information to my employer only to the minimum extent reasonably necessary to support return-to-work planning and accommodation.

I acknowledge that: (a) any overpayment of benefits constitutes a debt, recoverable in accordance with the plan; (b) my information will be retained as required by applicable law; (c) my information may be transmitted and stored electronically, and it will be protected in accordance with applicable laws; (d) I have the right to request access to and amendment of my information which is collected under this consent; and (e) I may revoke this consent at any time by providing written notice to 3sHealth. I acknowledge that revoking this consent may result in delays or termination of benefits.

I give this consent voluntarily. This consent remains valid for the duration of my claim and related matters unless withdrawn. A photocopy or electronic version of this consent is valid as the original. Questions about this consent may be directed to 3sHealth.

Plan member signature:

Date Signed:

dd/mm/yy