MEDAVIE BLUE CROSS™

APPLICATION FOR BENEFITS EMPLOYER'S STATEMENT

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-877-849-8509
FAX: 1-800-644-1722
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Group Name: _____

Store Number/Work Location: _____

Policy Number: _____ Division: _____

☐ Salary Continuation
☐ Short Term Disability/Weekly Indemnity
☐ Long Term Disability
☐ Waiver of Premium

Employee Name: _____
Last First Initial

SIN (only required for taxable plans): _____ Date Last Worked (DD/MM/YYYY): _____

Employee's Occupation on Date Last Worked: _____

(Please complete on reverse or attach formal Job Description Form or Physician Demands Analysis)

Is the employee's job being held for them? ☐ Yes ☐ No Date of Birth (DD/MM/YYYY): _____

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

Return to Work Date (DD/MM/YYYY): _____

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 (DD/MM/YYYY): _____ To (DD/MM/YYYY): _____ Carrier: _____

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_____ sick bank (number of days).

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

Type of income: _____ Date (DD/MM/YYYY): _____

Type of income: _____ Date (DD/MM/YYYY): _____

Employment Start Date (DD/MM/YYYY): _____

Employee's Effective Date of Coverage for Disability Benefits (DD/MM/YYYY): _____

Employee Classification: _____

$ _____

Earnings as of Date Last Worked:
☐ hourly_____hrs/wk
☐ weekly
☐ monthly
☐ yearly
☐ income tax deducted per pay period

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

$ _____ , $ _____ , $ _____

Date of last salary change (DD/MM/YYYY): _____

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 (DD/MM/YYYY): _____

FORM-399E 08/23

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JOB DESCRIPTION

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

Employee Name:	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 Performed	Not Performed Daily	Up to 1 Hour Daily	1 - 3 Hours Daily	+ 3 Hours Daily	Usual	Usual	
Lifting								
Pushing								
Pulling								
Manual Dexterity								

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

Activities		Frequency / Duration	Activities		Frequency / Duration
Inside Work	☐		Slippery Area	☐	
Outside Work	☐		Tools (sharp, hazardous)	☐	
Temperature (hot / cold)	☐		Machinery (electrical, vvibratory, motorized)	☐	
Humid / Dry	☐		Travelling	☐	
Dust	☐		Work Alone	☐	
Vapour Fumes	☐		Work in Group	☐	
Noise (degree)	☐		Interact with Public	☐	
Moving Objects	☐				

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 Signature: _____ Date (DD/MM/YYYY): _____