APPLICATION FOR BENEFITS
EMPLOYER'S STATEMENT

644 MAIN ST PO BOX 220
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
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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: SOFINA FOODS INC.

Main HR Contact: ______

Policy Number: 91839 Work Location: ______

❑ Salary Continuation
❑ Weekly Indemnity
❑ Long Term Disability
❑ Waiver of Premium

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: ______ YYYY | MM | DD To: ______ YYYY | MM | DD 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.

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: ______ YYYY | MM | DD Employee's Effective Date of Coverage: ______ YYYY | MM | DD

Employee Classification: ______

Earnings as of Date Last Worked:

$ ______

❑ hourly ______ hrs/wk
❑ weekly **If Commission Basis, please attach previous year's T4.**
❑ monthly
❑ yearly
❑ income tax deducted per pay period $ ______ , $ ______ , $ ______

❑ Commission Basis

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

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JOB DESCRIPTION

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

Employee Name: ❑ Mr. ❑ Mrs. ❑ Miss ❑ 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 Performed	Not Performed 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		**Frequency / Duration**	**Activities**		**Frequency / Duration**
Inside Work	❑		Slippery Area	❑	
Outside Work	❑		Tools (Sharp, hazardous)	❑	
Temperature (Hot / cold)	❑		Machinery (Electrical, vibratory, motorized	❑	
Humid / Dry	❑				
Dust	❑		Travelling	❑	
Vapour Fumes	❑		Work alone	❑	
Noise (degree)	❑		Work in Group	❑	
Moving Objects	❑		Interact with public	❑	

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: ______________