



| Healthcare Benefit Trust (HBT) Policy #51337 | |
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| Joint Community Benefits Trust (JCBT) Policy #59234 | |
| Joint Facilities Benefits Trust (JFBT) Policy #59233 | |
| Joint Health Science Benefits Trust (JHSBT) Policy #59232 | |

Claim for Long Term Disability Benefits

EMPLOYER'S STATEMENT OF AVAILABLE POSITIONS

This form is to be completed and submitted to Canada Life by the employer.

| Collective Agreement | NEW LTD CLAIMS | | | | | | | | | | |
|--|---|---|---------------------------------------|---|-------------------------|----------------------------|------------------------------------|---|--|--|--|
| Health Services and Support Community Subsector Agreement Health Services and Support Facilities Subsector Agreement Health Services and Support Facilities Subsector Agreement February 19, 2013 Required Health Science Professionals Collective Agreement April 3, 2013 Required Nurses' Provincial Collective Agreement Nurses' Provincial Collective Agreement NyA Optional Stiff Stiff LTD CLAIMS This form is optional for all existing claims – i.e. claims with a date of disability prior to the above effective dates. If an opportunity for a return to work is identified by the employer at any point in the claim, complete and submit this form the employer's responsibility to ensure that all positions meet the requirements of the applicable Collective agreement or Dplan (e.g. availability, rate of pay, FTE). EMPLOYER IDENTIFICATION (please print) | | | | - | | | | | | | |
| Health Services and Support Facilities Subsector Agreement Health Science Professionals Collective Agreement Health Science Professionals Collective Agreement Myl 5, 2013 Required April 5, 2013 Required Required April 5, 2013 Required April 4, 2013 Req | | | | | - | | | | | | |
| Health Science Professionals Collective Agreement Nurses' Provincial Collective Agreement N/A Optional EXISTING LTD CLAIMS This form is optional for all existing claims – i.e. claims with a date of disability prior to the above effective dates. If an opportunity for a return to work is identified by the employer at any point in the claim, complete and submit this form it chanada Life. Upon receipt, Canada Life will re-adjudicate the LTD claim based on the terms of the applicable Collective agreement of the employer's responsibility to ensure that all positions meet the requirements of the applicable collective agreement of the properties of the applicable collective agreement of the management of the employer is responsibility, rate of pay, FTE). EMPLOYER IDENTIFICATION (please print) Name of Employer: Contact Name: Phone #: EXT: EMPLOYER IDENTIFICATION (please print) Name of Employer Division #: Contact Name: Phone #: EXT: EMPLOYER IDENTIFICATION (please print) Available position(s) exist as per the applicable Collective Agreement (provide Position Details below) Position(s) exist that will facilitate return to work but do not meet the available definition outlined in the applicable Collective Agreement (provide Position Details below) Position(s) are NOT presently available POSITION DETAILS (attach supporting documentation for each position (i.e. job description, posting and functional/job demands analysis). Job Title Rate of FTE Status(Permanent Position Currently Start Date (if applicable) (if applicable) For additional positions attach separate sheet(s) Comments: DECLARATION (to be signed by person completing the form) hereby declare the above information is accurate and complete. Date Authorized Signature Name (please print) | | | | | | | | | | | |
| Nurses' Provincial Collective Agreement N/A Optional EXISTING LTD CLAIMS This form is optional for all existing claims - i.e. claims with a date of disability prior to the above effective dates. If an opportunity for a return to work is identified by the employer at any point in the claim, complete and submit this form to Lanada Life. Upon receipt, Canada Life will re-adjudicate the LTD claim based on the terms of the applicable LTD plan in the employer's responsibility to ensure that all positions meet the requirements of the applicable collective agreement of LTD plan (e.g. availability, rate of pay, FTE). EMPLOYER IDENTIFICATION (please print) Name of Employer: HBT Employer Division #: EXT: EMPLOYEE IDENTIFICATION (please print) Last Name: HBT Employer Division #: EXT: EMPLOYEE IDENTIFICATION (please print) Available position(s) exist as per the applicable Collective Agreement (provide Position Details below) Position(s) exist that will facilitate return to work but do not meet the available definition outlined in the applicable Collective Agreement (provide Position outlined in the applicable Collective Agreement (provide Position outlined in the applicable Collective Agreement (provide Position, posting and functional/job demands analysis). Job Title Rate of FTE Status(Permanent Position Currently Start Date (if applicable) Position(s) are NOT presently available Pay For additional positions attach separate sheet(s) Comments: DECLARATION (to be signed by person completing the form) hereby declare the above information is accurate and complete. Date Authorized Signature Name [please print) | | | | | | | | · | | | |
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| Name of Employer: | This form is <u>optional</u> fo opportunity for a returr Canada Life. Upon rece the employer's respons | r all existing claims n to work is identifie ipt, Canada Life will ibility to ensure tha | ed by the re-adjudi t all posit | employer at any p cate the LTD clain | oint in th 1 based o | e claim, co on the term | omplete and subrus of the applicab | nit this form to ble LTD plan. It is | | | |
| EMPLOYEE IDENTIFICATION (please print) Last Name: | EMPLOYER IDENTIFI | CATION (please pri | int) | | | | | | | | |
| EMPLOYEE IDENTIFICATION (please print) .ast Name: | Name of Employer: | me of Employer: | | | | | HBT Employer Division #: | | | | |
| | Contact Name: | | | | | Phone #: Ext: | | | | | |
| BT Benefits ID No. (BID): | | | | | | | | | | | |
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| Pay or Temporary) Available (if applicable) (if applicable) Yes No Pay Ses N | POSITION DETAILS (a analysis). | ttach supporting docu | mentation | for each position (i.e | e. job desc | ription, post | ting and functional | /job demands | | | |
| For additional positions attach separate sheet(s) Comments: DECLARATION (to be signed by person completing the form) hereby declare the above information is accurate and complete. DateAuthorized Signature | Job Title | | | | | | | End Date (if applicable) | | | |
| For additional positions attach separate sheet(s) Comments: DECLARATION (to be signed by person completing the form) hereby declare the above information is accurate and complete. DateAuthorized Signature | | | | | | + | | | | | |
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| (please print) Title Dept | I hereby declare the above | information is accura | te and con | iplete. | | | | | | | |
| Title Dept | Date | Authorized Signa | ature | | N | ame | /I | int) | | | |
| Phone Funcil Address | Title | | | Dent | | | | int) | | | |
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Submit to Canada Life:

Vancouver DMSO: Suite #1500-1055 Dunsmuir Street, Vancouver, BC V7X 1K8 | Fax: 1.844.816.1038 | Email: vancouver.dmso@canadalife.com

Langley DMSO: Suite #500 - 19933 - 88th Avenue, Langley, BC V2Y 4K5 | Fax: 1.844.569.3131 | Email: langley.dmso@canadalife.com