TeksMed
Seeing the **ability** in disability

Employer Statement of Absence for Short Term Disability (STD) Benefit Coverage

Instructions for completion:

1. **Complete all fields;**
2. **Save a copy of the completed form to your computer;**
3. **Open a new email message and attach the saved form to your email as you would a normal MS word document;**
4. **Address the email to claims@teksmed.com**

Employer must sign in Section 1: Company.

For clarification or assistance, please contact us toll free at 1-877-850-1021.

If you do not wish to use email, please print the completed form and send it via fax to 1-877-504-1777.

Section 1: Company	
Employer Name:	
Third Party Administrator Name:	
Third Party Administrator Phone #:	
Third Party Administrator Email:	
Date Form Completed:	
Signed By: x_____ Print Name_x_____	

Section 2: Designated Company Representative (Primary Contact for Claims)	
Last Name:	
First Name:	
Job Position/Title:	
Work Phone Number:	
Email Address:	
Fax:	

Section 3: Alternate Company Contact	
Last Name:	
First Name:	
Job Position/Title:	
Work Phone Number:	
Email Address:	
Fax:	

Section 4: Employee Information

Last Name:	
First Name:	
Date of Birth:	(DD/MM/YYYY)
Employee Number:	
Date of Hire:	(DD/MM/YYYY)
Job Position/Title:	
Date of Eligibility to Insurance Plan:	(DD/MM/YYYY)
Date Employee Joined the Plan:	(DD/MM/YYYY)
Work Phone Number:	
Work Phone Extension:	
Social Insurance Number:	
Union Affiliation:	☐ Yes ☐ No ☐ Not Specified
Employee's Preferred Language:	☐ English ☐ French
Home Phone Number:	
Address:	
City :	
Province:	
Postal Code:	

Section 5: Rate of Pay

Employee Status:

Pay Rate: per:

Please provide the employee's standard work schedule

(Number of hours worked per day)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Has the employee applied for disability benefits with any other company?

If so, please indicate below:

Company:	
Type of Insurance:	
Amount of Benefits:	per:
Benefits Taxable?	☐ Yes ☐ No ☐ Not Specified
Coverage Over and Above the Non-Evident Maximum?	☐ Yes ☐ No ☐ Not Specified

Employer Initials

Indicate which benefits are applied for, are receiving, or expect to receive from any of the following sources:

- ☐ Canada or Quebec Pension Plan Disability Benefit * Amount: $
  *__Important Note:__ Please attach a copy of the "Notice of Entitlement" or "Decline" Letter.
- ☐ Automobile Insurance Amount: $
- ☐ Worker's Compensation Board Amount: $
- ☐ Retirement Pension Plan Amount: $
- ☐ Employment Insurance Commission Amount: $
- ☐ Other Amount: $

Section 6: Work Requirements

Description of Work Environment:

Legend	
Occasionally	Less than 33% of the day
Frequently	34% to 66% of the day
Constantly	More than 67% of the day

Physical Demands	N/A	Occasionally	Frequently	Constantly
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Lifting & Carrying	☐	☐	☐	☐
Average Weight:	☐ Lbs	☐ Kgs		
Climbing Stairs	☐	☐	☐	☐
Repetitive Movements	☐	☐	☐	☐
Overhead Movements	☐	☐	☐	☐
Below Waist Movements	☐	☐	☐	☐
Hot Environment Exposure	☐	☐	☐	☐
Cold Environment Exposure	☐	☐	☐	☐
Typing / Use of Mouse	☐	☐	☐	☐
Communication with External Clients	☐	☐	☐	☐
Follows Detailed Instructions	☐	☐	☐	☐
Need for Constant Concentration	☐	☐	☐	☐
Complex Decision Making	☐	☐	☐	☐
Uses Public Transportation	☐	☐	☐	☐
Travels By Car	☐	☐	☐	☐

Employer Initials

Section 7: Information Concerning the Absence

1st Day of Absence:	(DD/MM/YYYY)
Absence Type:	☐ STD ☐ LTD
1st Day of Benefit Coverage:	(DD/MM/YYYY)
Duration of the Plan Benefits:	15 Weeks: ☐ 17 weeks: ☐ 26 weeks: ☐ Other: ☐
Type of Claim:	Accident: ☐ Illness: ☐ Hospitalization: ☐
Did the Illness/Injury occur while the Employee was on vacation?	☐ Yes ☐ No ☐ Not Specified
Scheduled date of return from vacation:	(DD/MM/YYYY)
To the best of your knowledge, are there any performance or employment issues, work changes, conflicts or concerns with absenteeism? * If Yes, please specify:	☐ Yes * ☐ No ☐ Not Specified

Section 8: Return to Work Status

Has the Employee Returned to Work?	☐ Yes * ☐ No ☐ Not Specified
* If Yes, Date Returned:	(DD/MM/YYYY)
* If Yes, what type and frequency of work?	Full Time: ☐ Part Time: ☐ * If Modified, specify:

Section 9: Availability for Modified Work

To facilitate early return to the workplace, which of the following can be accommodated?

- ☐ Progressive Return to Work
- ☐ Contact Restriction with External Clients
- ☐ Sitting Limitation
- ☐ Standing Limitation
- ☐ Lifting and Carrying Limitation
- ☐ Over the Shoulder Lifting Limitation
- ☐ Repetitive Movement Limitation

Section 10: Additional Information

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

Employer Initials ☐

Section 11: Declaration

I hereby declare that the answers to the above questions are accurate and complete

X _____

Supervisor or Authorized Signature:
Name and Title:

Phone:

Fax: