Guide for completing the PEBT LTD Employer Statement

Please contact your Desjardins HCMS or LTD Claim specialist,
or PEBT at www.pebt.ca "contact us"

A – IDENTIFICATION	
Field description	**Field answer guide**
Name of policy holder	Enter "Public Education Benefits Trust" in this field.
Telephone No.	Enter your school district's phone number.
Fax No.	Enter your school District's fax number.
Policy No.	Enter "64090L" in this field.
Address - No., street City/Province/Postal code	Enter your school district's mailing address.
Name of employee	Enter the employee's full and legal name *(please do not use nicknames).*
Certificate No.	Enter the employee's employee number for your school district.
Social Insurance No.	Enter the employee's social insurance number.
Address – No., street, apartment City/Province/Postal code	Enter your employee's home mailing address. Please ensure that this is updated otherwise benefits may be delayed.
Email address	Enter the employee's email address for use while they are absent.
Telephone no.	Enter the employee's phone number for use while they are absent.
Fax. no.	Enter the employee's fax number for use while they are absent *(if available)*.
Date of birth of employee	Enter the employee's date of birth. Please ensure this has been verified with at least one piece of government identification such as a birth certificate or driver's license.
COMPLETE IF SELF-ADMINISTERED	
Effective date of coverage:	Enter the date the employee first became eligible for LTD coverage following completion of three consecutive months as a regular employee working at least 15 hours per week.
Class no.	This is a four-digit number. a. The first two numbers are your school district number. Example: Southeast Kootenay School District is 05. b. The second two numbers are how many months per year your employee is expected to work, such as 12 months, 11 months, or 10 months. This should reflect the employee's regular duties as of the date of disability. For example, if the employee "owns" a 12-month position but was in a temporary 10-month position when they became disabled, then they would be considered a 10-month worker for long term disability (LTD). Also, an employee cannot be, for example, a 10.5-month worker; in this case, the school district must indicate if the employee is either a 10 or 11-month worker.

B – GENERAL INFORMATION	
Field description	**Field answer guide**
1. Pre-disability annual salary	In the 12-months immediately prior to the employee becoming disabled, was the employee promoted, did they receive a wage increase, or was the employee on an approved leave including sick, personal, education, maternity, caregiver, or compassionate care? a. If yes to any of the above, please take the employee's hourly rate in effect when the member became disabled multiplied by the number of hours per week they are expected to work multiplied by: i. 44 for 10-month workers ii. 48 for 11-month workers iii. 52 for 12-month workers b. If no, provide the total earnings for the previous 12 months starting from the last day worked. i. Include statutory holiday pay, vacation pay, and any premiums/allowances. ii. Do not include overtime. iii. Do not include earnings for work outside of the employee's regular duties such as if the employee takes extra shifts during the school year. As another example if the employee's regular duties are as a 10-month Education Assistant, but they perform extra administrative work in September to help with back to school, do not include the earnings for the administrative work. iv. However, if the employee's regular duties involve more than one job with the school district, then these earnings can be included. For example, if an employee is regularly an Education Assistant (.6FTE) and a Lunch Time Supervisor (.3 FTE), then please Include the regular earnings for both jobs. v. Do not include earnings outside of the employee's regular school year. For example, do not include earnings for July or August for 10-month employees.
2. Salary effective date	The date of the employee's most recent salary/wage increase or decrease prior to the last day worked.
3. Job status	Indicate whether your school district considers the employee full or part time.
4. Hours worked per week	The number of hours the employee is expected to work per week for their regular duties. For example, a 10-month Education Assistant who is expected to work five hours per day Monday to Friday works 25 hours per week.
5. Premium paid by	Leave this blank, this question is not required.
6. Date of employment	The date the employee first started working for your school district regardless of whether they were a regular or non-regular employee.
7. Occupation	The job title for your employee in effect immediately before the date of disability. Include more than one job title if your employee has more than one job as part of their regular duties.
8. First day of disability	The date that the employee or HCMS indicates was the first day the employee was disabled. If this is not known, then put the next calendar day following the last day the member worked their regular hours and regular duties.

B – GENERAL INFORMATION continued	
9. Did or will the employee receive any income during the disability period?	Indicate any payments made by the school district or union to the employee such as sick pay, salary continuance, maternity/paternity benefits, or earnings from a return-to-work program. It is not necessary to provide details about Employment Insurance.
10. If the employee is pregnant, has an application for a preventive withdrawal been, or will it be submitted to the CNESST?	Do not answer this question unless the employee has moved to Quebec; it is unnecessary.
11. Has a claim been filed with a government agency?	Indicate if the employee has filed a claim with WorksafeBC, ICBC, Canada Pension Plan, a human rights tribunal, or other. If this is not known you are not required to ask the employee, Desjardins will do this.
12. Has the employee returned to work?	Please indicate if the employee has come back to work either in regular or modified duties/hours. Alternatively, if the employee has indicated that they will return to work at a future date, please indicate this.
13. Is this person still in your employ?	Please indicate if the employee's employment has ended such as if they resigned or were terminated.
14. Is your employee eligible for an exemption under the *Indian Act (R.S.C. (1985), c 1-5)*?	Please indicate if the employee is currently receiving an income tax exemption for their school district pay or is claiming to be eligible for an income tax exemption under the *Indian Act*.

ADDITIONAL INFORMATION

Please provide any other information such as the following:

- List any previous stop and start dates for the employee's LTD coverage, such as due to a nonpaid leave of absence for 31 days or more.
- Provide any details about an employee's return-to-work program including their schedule.
- If this form as been submitted later than 180 days (approx. six months) following the employee's date of disability, please explain why.
- If the employee is planning to move, please also provide the new address.
- List any workplace issues Desjardins should know about.

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1024 STN A
Toronto ON M5W 1G5
Send original forms and keep copies for your records.

By fax:
1-855-678-8124 (toll free)
604-678-8124
Keep original forms for your records.

Desjardins Insurance
Life • Health • Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY CLAIM
EMPLOYER STATEMENT

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Name of policyholder	Telephone No.	Fax No.	Policy No.
	( ) -	( ) -	

Address - No., street | City | Province | Postal code

Name of employee	Certificate No.	Social insurance No.*

Address - No., street, apartment | City | Province | Postal code | E-mail address

Telephone No.: ( ) - Fax No.: ( ) -

Date of birth of employee (YYYY MM DD)

COMPLETE IF SELF-ADMINISTERED **Effective date of coverage:** (YYYY MM DD) **Class no.:**

* Social insurance number is necessary only if the disability claims are taxable.

B - GENERAL INFORMATION

If the benefits are taxable, the basic tax deductions will be made. In all other cases, please provide the appropriate tax forms.

1. Pre-disability annual salary	2. Salary effective date (YYYY MM DD)	3. Job status	4. Hours worked per week
$		☐ Full time ☐ Part time	

5. Premium paid by: ☐ Employer ☐ Employee ☐ Both

6. Date of employment: (YYYY MM DD) 7. Occupation:

8. First day of disability: (YYYY MM DD)

9. Did or will the employee receive any income during the disability period? ☐ Yes ☐ No **If yes**, indicate below:
(Type: maternity, disability, EI benefits, salary, lump sum, other)

Type: | **Amount:** | **Period:**

10. If the employee is pregnant, has an application for a preventive withdrawal been, or will it be submitted to the CNESST (Québec only)? ☐ Yes ☐ No

11. Has a claim been filed with a government agency? ☐ Yes ☐ No **If yes**, indicate below:
☐ CNESST / WCB / WSIB / WHSCC ☐ CPP / QPP ☐ SAAQ (Québec only)
☐ Other, specify:

Date filed: (YYYY MM DD) | **Decision rendered:** | **Amount:**

12. Has the employee returned to work? ☐ Yes ☐ No **If yes**, on what date? (YYYY MM DD)

13. Is this person still in your employ? ☐ Yes ☐ No **If no**, specify termination date: (YYYY MM DD)

Reason:

14. Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☐ Yes ☐ No
If so, please indicate the percentage of employment income that is not taxable: _____ %

ADDITIONAL INFORMATION

Last name and first name of the authorized person (PLEASE PRINT) | **Position**

Signature of the authorized person | **Date** | **E-mail address**