Application for Continuation of Pension Accrual While Disabled

SHEPP
People. Pensions. Results.

FORM ID: 047 CASE ID: _____

1 Personal Information

Member Information

First Name _____ Middle _____ Last Name _____

Date of Birth (dd/mm/yyyy) _____ Gender: ◯ Female ◯ Male Member ID# _____

Address and Contact Information

Has your address or contact information changed? ◯ No ◯ Yes

Address _____ City _____ Province _____

Country _____ Postal Code _____ Phone _____ Email _____

2 Claim Details

Describe your current typical daily activities _____

Describe any change in medical condition(s) since your last report _____

Please list the names of all physicians and medical practitioners currently involved in the investigation and treatment of your medical condition and your appointment dates.

Name of Physician _____ Appointment Date (dd/mm/yyyy) _____

Name of Physician _____ Appointment Date (dd/mm/yyyy) _____

Name of Physician _____ Appointment Date (dd/mm/yyyy) _____

Name of Physician _____ Appointment Date (dd/mm/yyyy) _____

During your current absence from work, have you participated in any type of activity which could be considered gainful employment? (e.g. home business, farming, spouse's business, etc) ◯ No ◯ Yes, Describe _____

Please indicate any other income you have received during your current absence from work:

◯ Auto Insurance (SGI) ◯ Canada Pension Plan (CPP) ◯ Workers' Compensation (WCB)

◯ Employment Insurance (EI) ◯ Other income (specify) _____

Important: You must attach a copy of any correspondence from the above agencies that indicate the type of income or benefit received, the amount received, and the effective date of the income or benefit received if you have not already submitted this information to SHEPP.

When do you expect to return to your regular occupation with your employer? (dd/mm/yyyy) _____

Note: Your failure to complete this form in its entirety may result in the form being returned to you, delaying the evaluation of your application.

3 Patient Authorisation

I hereby certify that the above answers are full and true to the best of my knowledge and belief, and I am aware that any intentional misrepresentation of facts could result in the immediate termination of my SHEPP disability pension accrual.

I authorise my physician, health care practitioner and any government agency, including the Workers' Compensation Board, Health Canada and Saskatchewan Government Insurance, to provide the Saskatchewan Healthcare Employees' Pension Plan with any information requested in connection with this claim. A photocopy of this authorisation shall be valid.

_____ _____

Patient Signature Date (dd/mm/yyyy)

Instructions

✓ **Submit this form to SHEPP**

✓ **Keep a copy for your files**

SHEPP recognises and respects the importance of your privacy. Personal information collected is used for the purpose of administering your benefits under the Plan.

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4 Physician's Statement

Notes to the Physician

This form is designed to help process your patient's SHEPP application for pension accrual while disabled. SHEPP will not cover any costs associated with the completion of this form. This section is to be completed by the physician and all questions must be answered in full.

Diagnosis of the medical condition primarily affecting your patient's ability to perform his or her occupation.

Describe any changes that have occurred in your patient's medical condition since the last statement. Please indicate any medical investigations or consultations that have been completed or are being arranged. Please provide dates and attach copies of specialists' reports and test results that are relevant to the medical condition causing the absence.

Describe the specific medical limitation or restrictions that are preventing your patient from working.

Indicate the current treatment program by checking the appropriate box and describe in the space provided.

- ☐ Names and dosages of medications
- ☐ Interactive treatments (e.g. physiotherapy, counselling)
- ☐ Date and type of surgery
- ☐ Hospital admission/discharge dates
- ☐ Future plans for surgery

What is the frequency of your patient's consultation with you or other medical practitioners since the last statement?

We realise that predicting recovery time is difficult, however we require a clear expectation of the length of absence from work. Please provide the date you anticipate your patient will be able to return to work or the length of time expected for recovery.

If you are unable to provide an estimated date of recovery, please indicate the date you will re-assess your patient.

Please provide any other relevant information (including other medical conditions, complications, or non-medical factors which may prolong your patient's disability).

5 Physician's Authorisation

Thank you for your assistance with this application.

Please print, type or stamp your name, specialty and address:

Phone

Fax

Email

Physician Signature

Date (dd/mm/yyyy)