beneplan

WEEKLY INDEMNITY CLAIM FORM

PART 2 - EMPLOYER'S STATEMENT:
(The employer must complete this section **after** it has been completed by the employee.)

Weekly Salary: $ _______________ Employee's last day at work prior to disability: ________________________________

To your knowledge, is the disability related to his/her occupation: ☐ Yes ☐ No	Is the employee covered by Workers' Compensation? ☐ Yes ☐ No	Has a Workers' Compensation claim been made or will it be made? ☐ Yes ☐ No

Do you know of any reason why this claim should **not** be paid?	Complete only if the benefit is taxable: Personal tax exemption per TD1: ☐ Federal $ ______________________ ☐ Provincial $ _____________________
Other comments:	
SIGNED ON BEHALF OF EMPLOYER: (Print name clearly) Name: Signature: Position/Title:	Date completed: (DD/MM/YYYY) Telephone Number: Fax Number:

Please return to: disability@beneplan.ca / Fax 416-863-6718 /
Beneplan Disability 500-150 Ferrand Dr Toronto ON M3C3E5 / 1-800-387-1670