



Please indicate address changes or corrections.

2017 LONG-TERM DISABILITY QUESTIONNAIRE

In accordance with the *Workers' Compensation Act*, adjustments to Long-Term Disability (LTD) benefits are made on the *anniversary month* of your injury or recurrence of injury.

- **Please read everything carefully and answer all that applies** in your case. If you require any additional assistance completing this questionnaire, please contact your claim manager.
 - To avoid any interruptions in your benefits, we request that you complete this questionnaire and return it **no later than March 31st, 2017** in the enclosed **pre-paid** and self-addressed envelope
 - **Include photocopies of income tax “T” slips for all 2016 income. *Do not send originals.***
 If you need to, you can contact the Canada Revenue Agency at 1 800 959-8281 and ask for copies of all **2016** T slips.
1. **Income Tax Exemptions:** We always use “Basic Personal Exemption”. If you claim *other* exemptions such as Disability or Spousal (for example, “I claim my wife/husband”), this may change your benefits. You must provide proof of other exemptions. **Check the box below that applies in your case.**

- I only claim ‘Basic Personal Exemption’ on my income tax return. I do not claim other exemptions.
- I claim Basic Personal Exemption *and I claim other exemptions* on my income tax return.

IF you claim other exemptions, contact Canada Revenue Agency at 1 800 959-8281 and ask for “**Information Printout RC-143 Option C for 2016**”. After you receive it, please send it to us. ***This is the only proof we accept.***

2. **Employment income:**

- (a) **I worked for an employer in 2016:** Yes No

Total **2016** employment earnings (total Box 14 on T4 slips): \$ _____

Employer: _____ Your position: _____

Phone No: _____ Hourly rate of pay: \$ _____

Contact person: _____

- (b) **I received employment insurance in 2016:** Yes No

Amount received from Employment Insurance in **2016** (Box 14 on T4-E slips): \$ _____

- (c) **I was self-employed or operated a business in 2016:** Yes No

- If Yes**
1. Send photocopy of your **2016 T-2125 Statement of Business Activities *and***
 2. Send information printout **RC 143-Option C for 2016** from Canada Revenue Agency
 3. Your deadline is extended to June 15th, 2017

Note: During the month of your sixty-fifth (65) birthday, your LTD benefits will cease. Following this, your file will be reviewed to determine your eligibility for an annuity amount. If you do qualify, you can expect to receive the annuity benefit within 4 to 5 months.

3. Financial remuneration:

(Please answer each item)

Please note – If you started receiving any of the income listed below and have not already called WorkSafeNB, please call 1 (800) 222-9775 immediately.

Are you receiving:	Yes	No	2017 monthly amount
Canada or Quebec Pension Plan <i>Disability</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
US Social Security <i>Disability</i> Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Insurance - Short-Term <i>Disability</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Insurance - Long-Term <i>Disability</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Employer Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Other Wage Loss Replacement	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
(Name provider) _____			
Other Pension or Benefit not listed above	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
(Name provider) _____			

Last year (in 2016) did you receive:			Amount
Lump sum severance or termination pay	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Any other income, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

REMEMBER: Send photocopies of all "T" slips you received for 2016.

DECLARATION

I certify that the statements made by me in this questionnaire are true and complete to the best of my knowledge. I am aware that if I knowingly and wilfully make false representation to WorkSafeNB, by action or omission, that causes WorkSafeNB to make payments or provide services that I would not have otherwise been provided, WorkSafeNB may file a criminal complaint with the appropriate police authority or a civil suit against me to recover any losses. I am also aware that my benefits may be withheld to repay any excess benefits that I have been paid because of any false representation I make to WorkSafeNB by action or omission. I hereby authorize WorkSafeNB to verify any and all information concerning my earnings from all sources.

Signature: _____ Date: _____
 Home phone: _____ Cellphone: _____
 SIN: _____ Date of birth: _____

Comments: _____

