WORKSAFE
TRAVAIL SÉCURITAIRE NB

1 Portland Street, P.O. Box 160
Saint John, N.B. E2L 3X9
Phone **506 632-2200**
Toll-free 1 800 999-9775
Web worksafenb.ca

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Saint John (N.-B.) E2L 3X9
Téléphone **506 632-2200**
Sans frais 1 800 999-9775
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Name:_____________________

Address:____________________

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Claim #:

2024 LONG-TERM DISABILITY QUESTIONNAIRE

Part A: 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.

****SEND THE FOLLOWING INFORMATION TO WorkSafeNB.****
(Delaying the return of this questionnaire may result in an interruption to your benefits)

- **QUESTIONNAIRE (Part A & B): Sign Part A & B** and return *before* **March 29, 2024** through your MyServices account. For instructions on how to sign up for MyServices and other ways to return your questionnaire, see page 4.
- **ALL 2023 INCOME TAX SLIPS** (originals will NOT be returned): For copies, call Canada Revenue Agency at 1 800 959-8281.
  - ➢ If you are waiting for tax slips, send the questionnaire with your comment "tax slips will follow later".

PLEASE COMPLETE THE FOLLOWING

1. INCOME TAX EXEMPTIONS:

Yes☐ **No**☐ I claim other tax exemptions in addition to personal basic*

***** To obtain proof of **"Caregiver"** exemption, *AFTER* you receive your Notice of Assessment, call Canada Revenue Agency at 1 800 959-8281. Ask for **"Information Printout RC143-1 E (11)X"** for the applicable tax year.

2. EMPLOYMENT INCOME IN THE YEAR 2023:

(a) **Yes**☐ **No**☐ I worked; **Yes**☐ **No**☐ More than 1 employer; **Yes**☐ **No**☐ Employed Now
(Please indicate most recent employer below. List names of additional employers in the comment section of page 2)

Total employment earnings (total Box 14 on T4 slips): $____________________

Employer: ____________________ Your position: ____________________

Phone No: ____________________ Hourly rate of pay: $ ____________________

Contact person: ____________________ Date of Hire (Month/Year): ____________________

(b) **Yes**☐ **No**☐ **I received *employment insurance:*** Amount? (Box 14 on T4-E slips): $____________________

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

If Yes
1. Send copy of your **T-2125 Statement of Business Activities *and***
2. Send information printout **RC 143** for the applicable year from Canada Revenue Agency
3. Your deadline is extended to June 14th, 2024

3. FINANCIAL REMUNERATION: Claim #:

Please note –

If you started receiving or have applied for any new income and have not already called WorkSafeNB, please call 1 (800) 999-9775 IMMEDIATELY. If your new income is determined to be a supplement to compensation, your WorkSafeNB benefit may be reduced. This may result in an overpayment which must be repaid to WorkSafeNB.

Are you receiving *(Do NOT report CPP Retirement)*: **This year's *monthly* amount**

Yes☐ No☐ Canada or Quebec Pension Plan ***Disability*** $____________________

Last year, did you receive (*Do NOT report WorkSafeNB benefits)***:** **Amount**

Yes☐ **No**☐ Any other income, please specify

Income Source:__________________________________ $____________________

Income Source:__________________________________ $____________________

Income Source:__________________________________ $____________________

Yes☐ **No**☐ Lump sum severance or termination pay $____________________

REMEMBER: Send copies of ALL the Tax slips you received for last year.

4. Since January of this year, have there been any significant changes to your employment situation? (For example: new job, pay increase, layoff, shortage of work, etc...) . If yes, please provide details in the comment section below.

☐ Yes ☐ No

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 willfully 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**: ____

Phone: ____ **Date of birth:** ______________________________

Comments: ____

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Part B. Status of your Workplace Injury and Employability

Claim #:

Section I. Status of your workplace injury

1. In recent years, has there been a change in your ability to participate in activities involving walking, sitting, climbing stairs, lifting or carrying objects? **(check one)**

   ☐ Improved ☐Same ☐Worsened (If **improved** or **worsened**, please explain): ____

2. Which health care providers are you currently seeing? **(check all applicable)**

   ☐Family Doctor ☐Nurse Practitioner ☐Psychologist ☐Specialist
   ☐Physiotherapist ☐Chiropractor ☐Occupational Therapist ☐Psychiatrist

   Other, please specify: ____________________________________

3. Please provide the names of the health care providers you checked in question #2.
   ____

4. Have you had any procedures or treatments related to your workplace injury (ex.as surgery, therapy) in the last year?
   ☐**Yes** ☐**No** If yes, please specify________________________________

5. In recent years, have you developed any medical conditions? If so, please specify:
   ____

Section II. Employability

6. Are you interested in receiving assistance with returning to the workforce? ☐**Yes** ☐**No**

7. Please briefly explain your answer in question 6.
   ____

8. In recent years, have you attended or completed any work-related training? ☐**Yes (specify below)** ☐**No**
   ____

9. If you moved in the past year or plan to move in the next 90 days, please provide your new or future address and effective date ____________________________________

I certify that the statements made by me in this questionnaire are true and complete to the best of my knowledge.

Signature: ______________________________ **Date:** ____________________

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Cette correspondance est offerte dans les deux langues officielles. Si le *Questionnaire relatif à l'invalidité à long terme* qui vous ont été envoyés ne sont pas dans la langue de votre choix, veuillez communiquer avec la personne responsable de votre réclamation au 1 800 999-9775.

Mes-Services

Nous offrons un service en ligne sécurisé vous donnant un accès facile à des renseignements sur votre réclamation. Le portail de Mes services vous permet d'en apprendre au sujet des services et des prestations; de voir l'état de votre réclamation et des dates de paiement; d'accéder à un système de courriel sécurisé; et encore plus. Pour apprendre comment vous inscrire et demander un NIP, allez à travailsecuritairenb.ca/messervices.

This correspondence is available in both official languages. If this Long Term Disability Questionnaire is not in the language of your choice, please contact your claims manager at 1 800 999-9775.

MyServices

We offer secure online service with easy access to some of your claim information. MyServices lets you learn about services and benefits, check claim status and payment dates, access secure email, and more. To learn how to register and request your MyServices PIN, go to worksafenb.ca/myservices.

To submit your questionnaire by email, attach the completed document and state "Annual Questionnaire" in the subject line, then send to application-demande@ws-ts.nb.ca.

WorkSafeNB reminds you that submitting documents through unsecure email networks increases privacy concerns. For more information, please read WorkSafeNB's Access to Privacy and Information statement.

Or, you can submit your questionnaire by mail or fax: WorkSafeNB, 1 Portland Street PO Box 160, Saint John, NB E2L 3X9. Fax toll-free: 1 888 629-4722