WORKSAFE TRAVAIL SÉCURITAIRE NB

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2020 LONG-TERM DISABILITY QUESTIONNAIRE

Name:
Claim #

Part A: Employment Status and all Remuneration
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.

To avoid any interruptions in your benefits, please:

- **Read everything carefully** and **answer all that applies.** You may contact your claim manager if you need help.
- **Include *photocopies (Do NOT send originals*) of income tax "T" slips for *all* 2019 income.** You can contact the Canada Revenue Agency at 1 800 959-8281 and ask for copies of all **2019** T slips if you need.
- **Return the completed questionnaire no later than March 27, 2020** in the enclosed **pre-paid** and self-addressed envelope **OR** fax to our toll free # 1 888 629-4722.

PLEASE COMPLETE THE FOLLOWING

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 claimed on your income tax return. **Check the box below that applies in your case.**

   I claim the following tax exemption(s):
   ☐ Basic Personal Exemption
   ☐ Basic Personal Exemption ***AND other exemptions***;

   - **For proof of "*other exemptions*"**, contact Canada Revenue Agency at 1 800 959-8281 and ask for **"Information Printout RC-143 Option C for 2019"**. Send us a copy when you receive it.

2. **Employment income:**

   (a) **I worked for an employer in 2019:** ☐ Yes ☐ No

   Total **2019** 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) **I received employment insurance in 2019:** ☐ Yes ☐ No

   Amount received from Employment Insurance in **2019** (Box 14 on T4-E slips): $____________________

   (c) **I was self-employed or operated a business in 2019:** ☐ Yes ☐ No

   If Yes 1. Send photocopy of your **2019 T-2125 Statement of Business Activities *and***
   2. Send information printout **RC 143-Option C for 2019** from Canada Revenue Agency
   3. Your deadline is extended to June 15, 2020

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.

3. Financial remuneration: (Please answer each item) Claim #

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	**2019 monthly amount**
Canada or Quebec Pension Plan *Disability*	☐	☐	$____________________
US Social Security *Disability* Pension	☐	☐	$____________________
Employer Insurance - Short-Term *Disability*	☐	☐	$____________________
Employer Insurance - Long-Term *Disability*	☐	☐	$____________________
Employer Sick Leave	☐	☐	$____________________
Other Wage Loss Replacement	☐	☐	$____________________
(Name provider) ___________________________			
Other Pension or Benefit not listed above	☐	☐	$____________________
(Name provider) ___________________________			
Last year (in 2019) did you receive:			**Amount**
Lump sum severance or termination pay	☐	☐	$____________________
Any other income, please specify ______________	☐	☐	$____________________

REMEMBER: Send photocopies of all "T" slips you received for 2019.

4. Since January 2019, have there been any significant changes to your employment situation? (For example: new job, pay increase, layoff, shortage of work, etc.). If yes, we will contact you for more details.

☐ 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:** ___________________________________

Home phone: ___________________________ **Cellphone:** _________________________________

Date of birth: ______________________________

Comments: ____

____

2020 LONG TERM DISABILITY QUESTIONNAIRE

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?** (circle one)
   Improved Same Worsened
   If improved or worsened, please explain:
   ____

2. **Which health care providers are you currently seeing?** (circle all applicable)
   Family Doctor Nurse Practitioner Psychologist Specialist
   Physiotherapist Chiropractor Occupational Therapist Psychiatrist
   Other, please specify: ______________________________

3. **In recent years, have you had any procedures or treatments related to your workplace injury such as surgery, therapy, etc.?** (circle yes or no) Yes No
   If yes, please specify: ______________________________

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

Section II. Employability

WorkSafeNB has different types of programs to help you transition to the workforce.

5. **Are you interested in receiving assistance with returning to the workforce?** (circle one)
   Yes No
   Comments: ____

6. **In recent years, have you attended or completed any work-related training?** (circle one)
   Yes No
   If yes, please specify: ____

7. **Have you moved in the past year, or do you plan to move in the next 90 days?** (circle one)
   Yes No
   If yes, please provide your new or future address and effective date
   ____
   ____

8. **Would you like a WorkSafeNB claims manager to contact you about the above responses?** (circle one)
   Yes No
   Comments: ____

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

Signature: ____ **Date:** ________________________