Unistar Special Risks Inc.

STD Disability Notification Form

TO BE COMPLETED BY UNISTAR SRI

Third Party Administrator

Company

Name of Claimant

First Day of Absence

Type of Claim **STD** **LTD**

Reason for Absence (STD) Accident Illness Hospitalization (more than 24 hrs)

TO BE COMPLETED BY THIRD PARTY ADMINISTRATOR

Confirm if employee is eligible for disability benefit yes no

STD
Waiting Period to apply days (based on reason for absence above)
Benefit payment period weeks

Insured Benefit per week Taxable yes no

LTD
Waiting Period to apply days
Own Occupation period years
Benefit payment period 1year,2 years or to 65

Insured Benefit per month Taxable yes no

Employee SIN **Sex**

Coverage over the NEM for either benefit If 'yes', give details below and fax Declaration of Insurability form to Toll Free: 800.364.0754

Are premiums paid up to date? If 'no', explain below

Notes

Date of Hire:
Date of Eligibility:
Date EE Joined the Plan:

Completed by **Date**

Telephone number

E-mail

If you have any questions regarding this form, please direct them to ahrenschindler@scm.ca