CANADA POST / POSTES CANADA

Employee Statement
Short-Term Disability Claim

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for disability benefits under the Canada Post Short-Term Disability Program. **A completed claim form with all relevant and pertinent information must be returned within 7 calendar days of the start of the disability to avoid interruptions in payments.** The completed form should be mailed or faxed directly to:

MORNEAU SHEPELL
50 BURNHAMTHORPE RD W SUITE 316
MISSISSAUGA ON L5B 3C2
Telephone: 1-855-554-3148
Fax: 1-877-562-9126

This form is not to be used for workplace injuries/illnesses.
Ask your team leader instead to provide you with the appropriate WCB form.

SECTION A Employee information (please print)

Employee name (last, first, middle initial):	☐ Mr. ☐ Ms.
Full address (street, city, province, postal code):	
Employee ID number:	Email:
Home phone number:	Alternate phone number:
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):

SECTION B Information about your work (please print)

Last day worked (dd/mm/yyyy):	☐ Full-time	Team leader's name:
First day of absence (dd/mm/yyyy):	☐ Part-time	
Expected return to work:	☐ Term employee greater than 6 months	Telephone number:
Job title:	Describe your job duties:	
Do you: ☐ Work alone ☐ Interaction with public ☐ Supervise others ☐ Drive/operate machinery		

SECTION C Information about your claim (please print)

Is your disability the result of: ☐ a non-work-related illness? ☐ a non-work-related accident? ☐ a motor-vehicle accident?

Describe how your illness/injury is impacting your abilities:

Have you had a similar or related condition? ☐ **No** ☐ **Yes** If yes, how long ago?

Do you feel capable to return to work if modified work is available?

Date and time of accident (if applicable):	Are you seeking reimbursement from a third party? ☐ **No** ☐ **Yes**

Briefly describe how and where the accident happened:

Were you hospitalized or admitted to a clinic (inpatient or outpatient)? ☐ **No** ☐ **Yes**

Name of Institution: Name of ward/unit:

Date admitted (dd/mm/yyyy): Date discharged (dd/mm/yyyy):