

NORTHWOOD

Dear Employee

We have been advised that you are unable to attend work due to a disability arising out of a non-work-related illness or injury. We sincerely hope that you will have an early recovery and wish to assist you wherever possible.

Included in this package are the following documents:

- Weekly Indemnity (WI) Forms:
  - Plan Member's Statement
  - Attending Physician's Statement
- Functional Abilities Assessment/Return to Work Form

### **Starting A Claim**

To initiate a WI claim, complete the Employee Statement, have your Attending Physician complete the Physician's Statement, and return the completed forms to Human Resources. Attach a void check or Direct deposit slip from your financial institution if you would like your payments deposited directly into your account. This is highly recommended in order to reduce any delays in you receiving your payment.

### **During Your Claim**

We will be working closely with the insurance provider to ensure your claim is managed in an effective manner. The insurance provider may utilize the services of an external rehabilitation provider to coordinate any rehabilitation programs (i.e., physiotherapy, etc.). During your absence from the workplace, the insurance provider, rehabilitation consultant or the Company may request updates on your condition from you and/or your treatment provider.

**We would like to remind you of your responsibility to maintain contact your supervisor on a weekly, or other scheduled basis to determine if there are any opportunities for modified duties or alternate work arrangements.**

### **Returning To Work**

Our mills have a well-established Disability Management Program, and we look forward to assisting you to reintegrate into the workplace by providing modified productive work until you are able to perform your regular job duties. In order to assist you, we require that you get the Functional Abilities Assessment/Return to Work form completed prior to your returning to work and/or assigning modified duties. Sedentary duties may be available for up to a tour without a Physician's Assessment/Return to Work Form. Speak with your supervisor about availability of sedentary duties.

If there are issues with your claim, contact Nicola Arnett – HR Advisor, or one of your Local Health & Wellness Committee members (see next page for contact information).

We encourage you to utilize the Employee and Family Assistance Program (EFAP) should you require such services during your period of disability.

If there is any additional assistance the company can provide, please contact your Supervisor.

Yours truly,

**Canfor Pulp Ltd.**

## NORTHWOOD

### Health & Welfare Committee Contact Information

#### **NICOLA ARNETT**

Human Resources Advisor – H&W Committee Co-Chair  
Northwood Pulp Mill  
Canfor Pulp Ltd.

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**T** 250-962-3631 **C** 778-349-0127 **F** 250-962-3638

[nicola.arnett@canforpulp.com](mailto:nicola.arnett@canforpulp.com)

5353 Northwood Pulp Mill Road, Prince George, BC, V2L 4W2

#### **JEFF PARLEE**

Millwright – H&W Committee Co-Chair  
Northwood Pulp Mill  
Canfor Pulp Ltd.

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**C** 778-349-0127

[jeff.parlee@canforpulp.com](mailto:jeff.parlee@canforpulp.com)

5353 Northwood Pulp Mill Road, Prince George, BC, V2L 4W2

#### **COLE LEGAULT**

Electrician – H&W Committee Member  
Northwood Pulp Mill  
Canfor Pulp Ltd.

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**C**

[cole.legault@canforpulp.com](mailto:cole.legault@canforpulp.com)

5353 Northwood Pulp Mill Road, Prince George, BC, V2L 4W2

#### **RYAN ZANETTE**

Millwright – H&W Committee Member  
Northwood Pulp Mill  
Canfor Pulp Ltd.

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**C**

[ryan.zanette@canforpulp.com](mailto:ryan.zanette@canforpulp.com)

5353 Northwood Pulp Mill Road, Prince George, BC, V2L 4W2

# Plan Member's Statement Claim for Disability benefits

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

## 1 Plan Member information

In order to avoid any delays in the assessment of your Short-Term Disability (STD) and where applicable, Long-Term Disability (LTD) claim, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If disability benefits under your Short-Term Disability or if applicable, Long-Term Disability Plan are taxable, your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Occupation	Job title	Social Insurance Number	
Home telephone number		Alternate telephone number	
What province were you living in at the time your coverage became effective under this plan?		Preferred language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French	

If you would like Sun Life Assurance Company of Canada ("Sun Life") to email you, please fill in your email address below. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

Email address
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## 2 Plan Sponsor information

Contract number	Member ID	Company name
Contact person	Contact person email	Contact person phone number

## 3 About your illness or injury

You must notify Sun Life if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

1. Please describe your present illness or injury and how it occurred.

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**3 About your illness or injury (continued)**

Date (dd-mm-yyyy)

2. When did your symptoms first appear?
3. Have you ever had the same or similar illness or injury?  No  Yes If yes, please explain and give dates.

Empty text area for question 3 response.

Date (dd-mm-yyyy)

4. Is your condition related to pregnancy?  No  Yes If yes, what is your delivery date?  
Please describe your complications, if any.

Empty text area for question 4 response.

Date (dd-mm-yyyy)

5. From what date did your illness or injury prevent you from working?
6. Please include a list of the duties of your job that you are unable to do.

Empty text area for question 6 response.

7. What treatments are you presently receiving (Medications, physiotherapy, psychotherapy, etc..)

Empty text area for question 7 response.

8. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

**3 About your illness or injury (continued)**

9. When do you expect to be able to return to work?   Full-time  
 Part-time

10. Have you tried to return to work already?  No  Yes If yes, please answer the following questions.

What were the dates that you returned to work? From  to

Did you return to:  your own job  new job or modified duties

Did you return to:  full-time  part-time

**4 Disability as a result of an accident**

1. Is your disability the result of an accident?  
 No If no, continue with the next section "Your other income".  
 Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location
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2. Were you working for your employer at the time of the accident?  No  Yes Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident?  No  Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number

3. If your disability is the result of an accident, are you taking legal action against any other person or organization?  
 No If no, explain why you are not taking legal action.

Yes If yes, please complete the following:

Name of lawyer		Telephone number	
Address	City	Province	Postal code

On what date did the legal action start?

Has a settlement been reached?  No  Yes If yes, please attach a copy of the terms of the settlement.

## 5 Your other income

Please list any amounts of money you are currently receiving or expect to receive each week or month from the following sources. We may take some of these amounts into consideration when we calculate your Short-Term Disability benefit.

Source	Insurance Co. & Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per <input type="checkbox"/> Week <input type="checkbox"/> Month	When are your benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. WCB/WSIB/CNESST, Union Disability Benefit, Creditor, Credit Cards, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Auto Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other Group/Association/Individual Plans		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Quebec Parental Insurance Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Canada/Quebec Pension Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Employer Disability, Severance or Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Any other Accident/Group/Association/Government Disability Benefit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other (specify) i.e. in Quebec, Criminal Victims Benefits		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	

## 6 Automatic deposit of your disability payments

This service is subject to the approval of your claim.

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. **If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque.** Please check with your Benefit Administrator to determine if this option is available to you.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

## 7 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan and we will verify the accuracy of the information given in support of your claim.

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

I certify that the statements in this form are true and complete.

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my claim. I authorize Sun Life and its reinsurers to collect, use and disclose information needed for underwriting, administration, adjudicating claims under the STD Plan and, where applicable the LTD plan to any person or organization who has relevant information pertaining to my claim including health professionals, institutions, investigative agencies, insurers and, where applicable, my Plan Sponsor. I agree that Sun Life and my Plan Sponsor may also share financial information related to my claim for purposes relevant to the management of both Plans. I understand that information about me pertaining to my claim may be reviewed in the event these Plans are audited.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the STD plan, and where applicable the LTD plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

*Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.*

Member's last name (please print)	First name
Member's signature X	Date (dd-mm-yyyy)

## 8 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.



If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.



You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to [disabilityclaims@sunlife.com](mailto:disabilityclaims@sunlife.com). Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.



You can fax your completed claim forms to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

### Halifax:

Fax: 1-866-639-7850

PO Box 11480 Stn CV

Montreal QC H3C 5P5

### Kitchener - Waterloo:

Fax: 1-866-209-7215

PO Box 100 Stn C

Kitchener ON N2G 3W9

### Montreal:

Fax: 1-866-639-7846

PO Box 11037 Stn CV

Montreal QC H3C 4W8

### Edmonton:

Fax: 1-866-639-7820

PO Box 2733 Stn Main

Edmonton AB T5J 5C9

### Toronto:

Fax: 1-866-639-7851

PO Box 950 Stn A

Toronto ON M5W 1G5

### Vancouver:

Fax: 1-866-639-7829

PO Box 48810 Stn Bentall

Vancouver BC V7X 1A6

## 9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit [www.sunlife.ca/privacy](http://www.sunlife.ca/privacy).



# Attending Physician's Statement Disability Claim



## Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada ("Sun Life") in making a decision on your patient's claim for disability benefits. The term "claim" as used throughout this statement relates to the assessment of the plan member's absence from work under the Short-Term Disability (STD) plan and where applicable, the member's absence from work under the Long-Term Disability (LTD) plan.

## Return address

Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

Edmonton: Fax: 1-866-639-7820 PO Box 2733 Stn Main Edmonton AB T5J 5C9	Toronto: Fax: 1-866-639-7851 PO Box 950 Stn A Toronto ON M5W 1G5	Halifax: Fax: 1-866-639-7850 PO Box 11480 Stn CV Montreal QC H3C 5P5	Montreal: Fax: 1-866-639-7846 PO Box 11037 Stn CV Montreal QC H3C 4W8	Kitchener - Waterloo: Fax: 1-866-209-7215 PO Box 100 Stn C Kitchener ON N2G 3W9	Vancouver: Fax: 1-866-639-7829 PO Box 48810 Stn Bentall Vancouver BC V7X 1A6
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## 1 Plan Member information and authorization to be completed by patient

Last name		First name		Home telephone number	Alternate telephone number
Address (street number and name)					Apartment or suite
City			Province	Postal code	
Plan Sponsor name				Contract number	Member ID number
Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)	

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature X	Date (dd-mm-yyyy)
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## 2 Attending Physician's Statement

**Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Section 2 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete all sections in full.**

<b>Diagnosis</b>	
Primary:	
Secondary:	
If childbirth: expected or actual delivery date (dd-mm-yyyy) <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	

**Occupational illness/injury** Is condition arising from employment?  Yes  No

<b>Start dates of current work absence</b>	Date of first visit during current period of absence (dd-mm-yyyy) _____
	First date of work absence due to condition (dd-mm-yyyy) _____

**2 Attending Physician's Statement (continued)**

**Hospitalization**

Has your patient been hospitalized  Yes  No Date admitted (dd-mm-yyyy) \_\_\_\_\_

Have they had day surgery?  Yes  No Date discharged (dd-mm-yyyy) \_\_\_\_\_

Name of institution: \_\_\_\_\_

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy) \_\_\_\_\_ Description \_\_\_\_\_ Type of anaesthetic \_\_\_\_\_

**Treatment** (Drug, dosage, physiotherapy, other)

**Prognosis** — Please provide the prognosis for recovery

**3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks**

**History** — Has the patient been treated for this condition in the past?  Yes  No If Yes, date(s) (dd-mm-yyyy) \_\_\_\_\_

**Visits** — Frequency of visits  Weekly  Monthly  Other \_\_\_\_\_

**Symptoms** — Describe current symptoms, severity and frequency.

**Investigations** — Please attach copies of all relevant:

- Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- Consultation reports

Please note that Genetic testing information is not required, so please do not include.

Are tests/investigations pending?  Yes  No If Yes, expected date of receipt (dd-mm-yyyy) \_\_\_\_\_

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist \_\_\_\_\_ Specialty \_\_\_\_\_ Date of visit (dd-mm-yyyy) \_\_\_\_\_

**Restrictions and limitations** — Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

**Complications and other condition(s)** — Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

**Compliance to treatment** — To your knowledge, is the patient following the recommended treatment program?  Yes  No

**Competency** — In your opinion, is your patient competent to manage his/her own affairs?  Yes  No

**Prognosis** — Please provide the prognosis for recovery (if not completed on page 1)

#### 4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Last name of attending physician (please print)	First name	Certified specialist		Physician's stamp
Address (street number and name)				
City		Province	Postal code	
Telephone number	Fax number			
Physician's signature X			Date signed (dd-mm-yyyy)	
<b>NOTE: Your patient is responsible for any charge made for the completion of this form.</b>				



Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.





# CONFIDENTIAL

NORTHWOOD PULP MILL  
P.O. Box 9000  
Prince George, B.C. V2L 4W2

Phone: 250-962-3630  
Fax: 250-962-3638

## FUNCTIONAL ABILITIES ASSESSMENT / RETURN TO WORK FORM

Note: If there is a charge associated with the completion of this form, payment is the responsibility of the patient.

### Employees Consent:

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Date of Injury/Illness: \_\_\_/\_\_\_/\_\_\_ Last Day Worked: \_\_\_/\_\_\_/\_\_\_ Date of Most Recent Medical Assessment: \_\_\_/\_\_\_/\_\_\_  
Y M D Y M D Y M D

I consent to the release of the following information to my employer for the purpose of determining my ability to work.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Y M D

### Physician's Assessment of this employee's ability to perform his/her duties:

- Able to return to regular duties on Date: \_\_\_/\_\_\_/\_\_\_  
Y M D
- Is able to return to work with certain job modifications/restrictions required. (For nature of restrictions see below)  
Indicate duration of modified work: \_\_\_\_\_
- Require Job Task Information Reassessment Date: \_\_\_/\_\_\_/\_\_\_  
Y M D

### Limitations/Restrictions on Activities:

Yes  No If "yes", please indicate with an (x) the specific limitations.

#### Neck

- Above-shoulder and overhead activity
- Other (please specify)

#### Back

- Repetitive trunk movement
- Heavy Lifting
- Lift weight exceeding \_\_\_\_\_ kg.
- Other (please specify)

#### Upper Extremity

- right  left
- Use right/left arm repeatedly
- Perform handling (seizing, grasping, holding, or turning objects)
- Perform fingering (picking, pinching or otherwise working with fingertips)

#### Shoulder

- right  left
- Repetitive shoulder movement
- Heavy lifting
- Reach above shoulder height
- Other (please specify)

#### Lower Extremity

- right  left
- Repetitive movement of the involved joint
- Prolonged weight bearing
- Walk or stand continuously
- Other (please specify)

#### Other

- Working alone
- Working on ladders or elevated areas
- Operating heavy/moving equipment
- Climb stairs or ladders
- Exposure to extremes in temperature
- Other (please specify)

Any side effects from medication that we should be concerned about: (i.e., driving; heights; working alone)

### Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Physician's Name, Address, Phone and Fax Number:

Physician's Signature: \_\_\_\_\_

Date Signed: \_\_\_/\_\_\_/\_\_\_  
Y M D

