

# Rehabilitation earnings statement

Long-Term Disability Insurance (LTD) – Industrial Alliance Insurance and Financial Services Inc.

Instructions:

- Please FAX the completed form to: 1-877-781-1583
- Please provide a completed form at the end of each month during the rehabilitation program.

## 1 To be completed by employer

Ensure each field is completed. If not applicable, indicate n/a.

Employee's last name		Employee's first name	
Group Policy Number	Certificate number <b>CI</b>	Department/Paylist	
G68-1400			

Each month, please provide the insured current annual salary of the employee's pre-disability job (if the employee was part-time, ensure you are providing the salary for the pre-disability hours).

Current annual salary  
\$

Are there any insurable allowances (e.g. bilingual bonus, etc.)? ☐ No ☐ Yes If yes, please provide the

Type	Amount \$
Type	Amount \$
Total (current insured earnings) \$0.00	

Hours per week

following:

Pre-disability job number of hours:

Date (dd-mm-yyyy)

Has the employee returned to their regular pre-disability work schedule? ☐ No ☐ Yes If yes, provide date:

### Rehabilitation earnings

- For the first month of the gradual return to work, please provide the employee's earnings from the first day of the return to work to the last day of the month.
- For the last month of the gradual return to work, please provide the employee's earnings from the first of the month up to the day before the return to their regular pre-disability work schedule.

From	To	Number of hours	Gross earnings (including all allowances)
Date (dd-mm-yyyy)	Date (dd-mm-yyyy)		
Hours paid			\$
Other earnings (please specify in the comments section below)			\$
Total		0	\$

Does the employee work weekends? ☐ No ☐ Yes

1
To be completed by employer (continued)

Comments

2
Compensation service contact information

Contact person's last name		Contact person's first name	
Title		Telephone number	Extension
Email address			Date form completed (dd-mm-yyyy)