



1. GENERAL

- 1.1 The Division shall provide protection for its employees against loss of income sustained because of illness or disability, quarantine, hospitalization, medical, dental or chiropractic examination or treatment or because of an accident or illness for which compensation is not payable under the Workers Compensation Act. Sick leave shall not be used for medical appointments, examinations or treatments which can be scheduled outside of working hours.

2. SICK LEAVE - TEACHING AND CLINICAL STAFF

- 2.1 Sick leave shall be calculated on the basis of 20 days per school year. For the purpose of computing sick leave for a fraction of a year, 200 days shall be considered to be the number of school days in a year.
- 2.2 Unused sick leave in any school year (including the 20 days from the current year) may be accumulated and carried forward to the next year up to the maximum of 145 days subject to the following conditions:
- 2.2.1 Upon commencement of duties in the first year, a teacher is entitled to 20 teaching days.
- 2.2.2 Upon commencement of duties in the second year, a teacher is entitled to twenty (20) teaching days and any unused sick leave from the first year.
- 2.2.3 At the beginning of the third year a teacher is entitled to 20 teaching days and any unused sick leave from the first two years.
- 2.3 Sick leave entitlement shall be computed from the date of the last continuous engagement.
- 2.4 Absence for illness due to pregnancy shall be considered to be sick leave up to the day the teacher was last present for duty.
- 2.5 No sick leave shall be granted during a period of leave of absence or sabbatical leave, nor shall any days be added to the accumulated sick leave for such periods.
- 2.6 Deduction of full salary (1/200th of annual salary rate for each day) shall be made when illness extends beyond the employee's entitlement to sick leave.
- 2.7 A teacher placed on leave of absence for reasons of health shall be informed by the Superintendent of the following:
- 2.7.1 the services provided by the W.T.A., including those of the Teacher Welfare Committee and its Teachers' Counsellor;
- 2.7.2 the sick-leave benefits which may be claimed;
- 2.7.3 the W.T.A. Benevolent Fund.

A printed statement of these services shall be given to the teacher.

3. SICK LEAVE - SUPPORT STAFF

- 3.1 When an employee other than teaching or clinical staff is ill, if the illness is certified by a physician, who may be appointed by the Division, the employee is entitled to salary during such illness as follows:



- 3.1.1 year one (1) of employment 12 days
- 3.1.2 year two (2) of employment 15 days
- 3.1.3 year three (3) of employment 20 days
- 3.1.4 year four (4) of employment 26 days and subsequent years
- 3.1.5 Sick leave shall be earned at the rate of one-twelfth (1/12th) of the annual entitlement outlined in this paragraph for each month of employment.
- 3.1.6 Part-time employees shall accumulate sick leave on a pro-rata basis.
- 3.2 An employee who has used less than twelve (12) days of sick leave in the first year of employment, or less than fourteen (14) days of sick leave in any one (1) year thereafter, shall be entitled to an accrual of unused sick leave for future benefits equivalent to twelve (12) or fourteen (14) days, as the case may be, less the number of days of sick leave utilized in that year.
- 3.3 Effective April 1, 1999, employees other than employees of the Administrative 11-20 group and teaching and clinical staff shall be entitled to sick leave on the following basis:
 - 3.3.1 during the first year of continuous service, one (1) day per month, (twelve (12) days per year)
 - 3.3.2 during the second year of continuous service, one and one-quarter (1 1/4) days per month, fifteen (15) days per year)
 - 3.3.3 during the third year of continuous service, one and two-thirds (1 - 2/3) days per month, twenty (20) days per year)
 - 3.3.4 during the fourth year and subsequent years of continuous service, two (2) days per month (twenty-four (24) days per year).
- 3.4 Sick leave shall be pro-rated on the basis of the employee's assigned hours of work as a percentage of regular full-time hours.
- 3.5 Unused sick leave in any month may be accumulated and carried forward to the next month up to a maximum of 180 days. An employee who had in excess of 180 days of sick leave as at April 1, 1999 shall be entitled to retain such excess accumulated sick leave but shall not be entitled to accumulate any additional sick leave until such time as the accumulated leave falls below 180 days.
- 3.6 Sick Leave is not payable to an Employee:
 - 3.6.1 who is engaged in employment for wage or profit with another employer except when such employment occurs as a result of a program of rehabilitative employment approved by the long term disability insurance plan, or when such employment is an additional employment that has been concurrently held by the employee and is one that is not incompatible with the employee's medical condition.
 - 3.6.2 whose illness results from the use of drugs or alcohol and who is not receiving continuing treatment from a licensed physician or in a recognized program of treatment for the use of drugs or alcohol.
 - 3.6.3 who, in respect of an illness or injury resulting from a motor vehicle accident, is receiving wage loss replacement benefits from the Manitoba Public Insurance Corporation to the extent that such benefits and paid sick leave exceed the employee's normal salary.
- 3.7 After an employee has exhausted all sick leave credits, the employee may use for bona fide sick leave purposes any overtime or compensating credits or vacation credits available to their credit.



POLICY: GCBDA
SUBJECT: SICK LEAVE/DISABILITY COVERAGE
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4. INCREASE OF PERIOD OF SICK LEAVE

4.1 The period of sick leave allowed to an employee may be increased at the discretion of the Board.

5. WORKERS COMPENSATION SICK PAY

5.1 When an employee is in receipt of Workers Compensation benefits, the Division will supplement the employee's Workers Compensation benefits such that the employee's combined income shall equal one hundred percent (100%) of standard pay.

5.2 Any supplement paid in 5.1 above will be deducted from the employee's sick leave credit.

5.3 Sick leave shall accrue for up to one (1) year while an employee is receiving Workers Compensation benefits.

6. SICK LEAVE DURING VACATION

6.1 If an employee, except for teaching and clinical staff, is hospitalized while on vacation, the employee shall qualify for sick leave credits.

6.2 Upon proof of hospitalization, the Division shall increase the employee's vacation credits and decrease sick leave credits.

7. CERTIFICATES FOR ABSENCE FOR ILLNESS

7.1 Employees absent on account of illness shall present a certificate to the Principal or Supervisor on return to duty. (See Exhibits 1 and 2.)

7.2 If the absence does not exceed three consecutive working days, the certificate may be a statement from the employee on the form provided which shall be signed by the employee and countersigned by the Principal or Supervisor. At the option of the employee, a regular medical certificate may be provided in place of the certificate mentioned above.

7.3 If the absence exceeds three consecutive working days or is for a contagious disease or condition, the certificate shall be signed by a registered medical doctor on the form provided for this purpose. If the employee presents a certificate from a person other than a registered medical doctor it shall be referred to the Director of Human Resources for acceptance.

7.4 Notwithstanding the foregoing, an employee may be required to furnish a medical certificate for any absence for illness if requested to do so by the Director of Human Resources or designate.

8. ACCUMULATED BUT UNUSED SICK LEAVE

8.1 Employees withdrawing from the Division for whatever reason shall not be paid for any sick leave credits accumulated due to length of service.

9. SALARY CONTINUATION - TEACHING AND CLINICAL STAFF

9.1 The Division shall administer a long-term disability salary continuation insurance plan for the Winnipeg Teachers' Association. Eligibility for the plan will be in accordance with details of the plan.

9.2 Deductions of Salary Continuation premiums at the source are authorized.

10. EMPLOYEES COVERED BY COLLECTIVE AGREEMENTS

10.1 Where provisions regarding sick leave or disability exist within a collective agreement, they shall apply.



ADMINISTRATIVE RULE/

PROCEDURE:

GCBDA-R(1)

SUBJECT:

**EMPLOYEE ACCIDENTS/
WORKERS COMPENSATION
MANITOBA PUBLIC
INSURANCE BENEFITS**

APPROVAL DATE:

December 8, 1987

REVISION DATE:

November 3, 2003, August 25, 2008

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Regulations governing procedures and operations for sick leave as determined by the Chief Superintendent.

1. Employee Accidents

- 1.1 An employee who becomes injured in the course of performing their duties must complete the Employee Accident Report Form (Exhibit GCBDA –E(6) and provide the form to their immediate supervisor.**
- 1.2 The immediate supervisor will provide the appropriate information on the form and forward the form to the principal/administrator/manager.**
- 1.3 The principal/administrator/manager will review the information for completeness and accuracy, sign and forward the document to the Human Resources Department.**

2. Workers Compensation Claims.

- 2.1 An employee who becomes injured or ill in the course of performing his/her duties must report such injury or illness as soon as possible to his/her immediate supervisor.
- 2.2 An employee unable to work because of work-related injury or illness will inform the Division immediately, in accordance with established procedures, so that a claim for compensation benefits can be forwarded to the Workers' Compensation Board ("WCB"). Workers Compensation payment will be paid directly to the employee by WCB, except where an advance is paid to the employee. The WCB shall be notified by the Division of any advance payment made to an employee. The amount of the advance shall be paid to the Division by WCB.
- 2.3 By written application from the employee, the Division will supplement the award made by the WCB from the employee's accumulated sick leave. The total amount paid by the WCB and the Division shall not exceed 100% of net take-home pay. For the purpose of this Article, net salary is defined as the employee's regular salary less Employment Insurance commission contribution, Canada Pension Plan contributions and income tax.
- 2.4 Where an employee has applied for WCB benefits and where a loss of normal salary would result while awaiting a WCB decision, the employee may elect to submit an application in writing to the Division requesting an advance subject to the following conditions:
 - 2.4.1 Advance payment(s) shall not exceed 90% of the employee's basic salary, less the employee's usual income tax deductions, Canada Pension Plan contributions, and EI contributions.
 - 2.4.2 The advance(s) will cover the period of time from the date of the injury until the date of the final WCB decision is received. In no case shall the total amount of the advance exceed 100% of the value of the employee's accumulated sick leave protection credits.
 - 2.4.3 The employee shall reimburse the Division by assigning sufficient WCB payments to be paid directly to the Division to offset the total amount of the advance. If the amount of the advance exceeds the WCB payment, the employee will be required to pay back that amount to the Division. If the employee is paid directly by WCB when an advance payment has been made, the Division may recover the advance by payroll deduction.
 - 2.4.4 In the event that the WCB disallows the claim, including any appeal, the employee shall be paid for the absence in accordance with the sick leave provisions of the Division and the Division shall recover any deficiency by payroll deduction from the employee. Recovery of any such deficiency shall be made in a fair and reasonable manner, but not over a period of time in excess of the period during which the advance was provided.



ADMINISTRATIVE RULE/

PROCEDURE:

GCBDA-R(1)

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**EMPLOYEE ACCIDENTS/
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2.4.5 Notwithstanding the foregoing, the amount that an employee will be entitled to be paid will be reduced, where necessary, in order to ensure that the payment does not result in a reduction in the amount of compensation that would otherwise be paid under any Workers Compensation legislation and/or regulations.

2.4.6 An employee who is in receipt of Workers Compensation benefits shall continue to receive all benefits for a maximum of one (1) year from the date of original injury. After one (1) year, only the following benefits will apply: pension, group insurance, and accumulation of service for the purpose of calculating vacation credits but not the accumulation of credits.

3. Manitoba Public Insurance Claims

3.1 An employee who is unable to work because of injury sustained in a motor vehicle accident, must advise their supervisor as soon as possible and must submit a claim for benefits to Manitoba Public Insurance ("MPI"). The employee shall be entitled to receive full sick leave benefits for any period of time deemed to be a "waiting period" by MPI.

3.2 By written application from the employee, the Division will supplement the award made by MPI from the employee's accumulated sick leave. The total amount paid by MPI and the Division shall not exceed 100% of net take-home pay. For the purpose of this Article, net salary is defined as the employee's regular salary less Employment Insurance commission contributions, Canada Pension Plan contributions and income tax.

3.3 Where an employee on MPI has applied for MPI benefits and where a loss of normal salary would result while awaiting a decision, the employee may elect to submit an application in writing to the Division requesting an advance subject to the following conditions:

3.3.1 Advance payment(s) shall not exceed 90% of the employee's basic salary, less the employee's usual income tax deductions, Canada Pension Plan contributions, and EI contributions.

3.3.2 The advance(s) will cover the period of time from the date of the injury until the date the final MPI decision is received. In no case shall the total amount of the advance exceed 100% of the value of the employee's accumulated sick leave protection credits.

3.3.3 The employee shall reimburse the Division by assigning sufficient MPI payments to be paid directly to the Division to offset the total amount of the advance. If the amount of the advance exceeds the MPI payment, the employee will be required to pay back that amount to the Division. If the employee is paid directly by MPI when an advance payment has been made, the Division may recover the advance by payroll deduction.

3.3.4 In the event that MPI disallows the claim, including any appeal, the employee shall be paid for the absence in accordance with the sick leave provisions of the Division and the Division shall recover any deficiency by payroll deduction from the employee. Recovery of any such deficiency shall be made in fair and reasonable manner, but not over a period of time in excess of the period during which the advance was provided.

3.3.5 Notwithstanding the foregoing, the amount that an employee will be entitled to be paid will be reduced, where necessary, in order to ensure that the payment does not result in a reduction in the amount of compensation that would otherwise be paid under any Manitoba Public Insurance legislation and/or regulations.

3.3.6 An employee who is in receipt of MPI benefits shall continue to receive all benefits for a maximum of one (1) year from the date of original injury. After one (1) year, only the following benefits will apply: pension, group insurance, and accumulation of service for the purpose of calculating vacation credits



ADMINISTRATIVE RULE
PROCEDURE GCBDA-R(2)
SUBJECT: NOTIFICATION OF OCCUPATIONAL
INJURY/ILLNESS
APPROVAL DATE: March 5, 2001
REVISION DATE: November 3, 2003
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Regulations governing procedures and operations for the notification of occupational injury/illness as determined by the Chief Superintendent:

1. General

- 1.1 In The Winnipeg School Division, all employees (full-time, part-time, temporary and casual), with the exception of teachers who are not vocational or industrial arts teachers, are eligible for benefits under the Workers Compensation Act of Manitoba. The procedures described herein have been established to provide a process to inform the Division of employee related injury/illness, to ensure that employee's welfare and benefits are protected, and to protect supervisors and the Division from legal action. In some instances, a follow-up process may be necessary, and an investigation may be conducted regarding the cause and effect of the accident. Workers Compensation coverage is in place for employees from the time they arrive on the Division's property until the time they leave, provided they are there for work-related purposes. Any hazard of the workplace, which results in an injury to an employee may represent a compensable claim, under *The Workers Compensation Act*.
- 1.2 Injured employees who are covered under Workers Compensation benefits will be made fully aware of their rights and responsibilities under *The Workers Compensation Act*. Follow-ups will be completed on all employees with compensable claims. The Human Resources Department will be responsible for processing all claims, and working with the Workers Compensation Board of Manitoba.

2. Roles and Responsibilities

2.1 The Employee Shall:

- a) Immediately notify the Division of an absence:
- i. custodians shall contact the Head/Chief Caretaker as well as the Building Department and report date, time, reason and length of absence, if known. Head/Chief Caretakers shall notify the Principal or designate as well as the Building Operations Section.
 - ii. all other employees shall contact the Supervisor/Administrator as well as the Substitute Employee Management Systems (SEMS) and report date, time, reason and length of absence, if known.
- b) obtain necessary First Aid and/or medical attention. If time loss from work results, medical validation/certification must be obtained and submitted to the appropriate supervisor/administrator and the Human Resources Officer.
- c) immediately report, both verbally and in writing, any occupational injury/illness to their supervisor/administrator and co-operate with any required accident investigation follow-up.
- d) in all cases of occupational injury/illness, immediately obtain and complete the Employee Accident and Workers Compensation Report form 2-10, and submit it to their supervisor/administrator for review and processing (GCBDA-E(6)).
- e) in time loss situations, provide their supervisor/administrator and the Human Resources Officer with medical validation/certification, including anticipated return to work date, if known.
- f) contact the Human Resources Officer with any questions concerning the WCB claims process and to obtain a Capabilities Assessment Form, which includes signing an authorization for release of medical information to take to their medical practitioner (GCBDA-E(8)).



ADMINISTRATIVE RULE
PROCEDURE GCBDA-R(2)
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2.3 The Human Resources Officer shall:

- a) liaise with the Workers Compensation Board and act as the Division's primary contact concerning all matters pertaining to compensation issues.
- b) receive Employee Accident and Workers Compensation Report and accompanying Accident Investigation Reports and immediately follow-up with each employee and the supervisor/administrator, whether there is time loss or not, for the purpose of obtaining further details concerning the accident/injury.
- c) when necessary, conduct an Accident Investigation, particularly when a cause and effect relationship between an accident and injury is difficult to establish through submitted reports (GCBDA-E(6) & GCBDA-E(7)), by way of work-site visitation/inspection, witness interview(s) and/or requesting further medical information.
- d) ensure that all relevant steps in the accident/injury reporting process have been followed and in turn prepare a detailed Employer Report of Injury or Occupational Disease (GCBDA-E(6)) on behalf of the Division for submission to the Workers Compensation Board within five (5) business days of being notified of the accident/injury taking place.
- e) Forward copies of the completed Employer Report of Injury or Occupational Disease to the Payroll Manager and keep the Payroll Manager informed of the status of the claim.
- f) act as an internal resource to all employees and supervisors/ administrators concerning Workers Compensation issues, and, where necessary, advocate on behalf of Division employees with the Workers Compensation Board.
- g) determine the appropriateness of claims on behalf of the Division based upon medical, procedural and/or legal grounds, and, where necessary, initiate challenges with the Workers Compensation Board.
- h) obtain signed authorization for release of medical information from employee and forward a Capability Assessment Form to their treating practitioner as required to facilitate early return to work (GCBDA-E(8)).
- i) receive, review and clarify the completed Capabilities Assessment Form and any identified restrictions/ limitations.
- j) co-ordinate the implementation of employee modified return to work programs with appropriate supervisors/administrators, Human Resources Assistants and Unions/Associations.
- k) document the terms and conditions associated with return to work programs and ensure that all concerned parties are provided with copies of the documentation.
- l) closely monitor the progress of all employees on modified return to work programs and through medical updates and work-site feedback from both the employee and supervisor/administrator, co-ordinate any and all necessary adjustments to the program until the employee is deemed fit to perform full/regular duties as determined by the treating practitioner and/or Workers Compensation Board.
- m) consult with the appropriate Human Resources Assistant concerning employees who have permanent restrictions resulting in their inability to continue working in the regular occupation for the purpose of exploring alternative job assignments within their existing work location and/or Division.
- n) facilitate vocational rehabilitation for employees with the Workers Compensation Board if job opportunities are not available within the Division that are suitable to the employee's physical limitations and job skills and/or if preventative rehabilitation benefits and services are being offered by the Workers Compensation Board.
- o) provide periodic summaries of all accidents to the appropriate Superintendent or Department Director.



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GCBDA-E(1)
 SICK LEAVE/DISABILITY COVERAGE
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(Medical Certificate - Form 3-4 (over 3 days absence))

The Winnipeg School Division

Medical Certificate

Covering Absence on Account of Illness of

_____ (give full name)

_____ (School or Department)

Winnipeg

_____ (date)

To the Secretary-Treasurer,
 The Winnipeg School Division

This is to certify that I have examined the above named individual who has been absent from work.

from _____ to

a total of _____ working days.

- The above named person is now physically fit to resume duty and is free from any disease which might be communicated to the students or others.
- The above named person is not physically fit to resume duty.

_____ M.D

.

_____ (Office Address)

INSTRUCTIONS: Principals or Department Heads should provide each employee with a copy of this form to be kept at home in order that it will be available if required. Employees when absent more than 3 consecutive working days on account of illness shall file a medical certificate immediately upon return to duty. Such certificate shall be filed with the principal of the school in which employed or the Department Head as may be appropriate, who in turn will forward it to the Secretary-Treasurer, by the end of the month in which the absence occurred.



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Medical Certificate - Form 3-4A (up to 3 days absence)

The Winnipeg School Division

Certificate Covering

Absence on Account of Illness of

(give full name)

(School or Department)

(date)

To the Secretary-Treasurer
 The Winnipeg School Division

THIS IS TO CERTIFY that I have been absent from my duties on account of

Illness

Medical/Dental
 Appointments

for a total of _____ working days, the date(s) of my absence being as follows:

_____, 20__ A.M. P.M.

I hereby certify that to the best of my knowledge I am fit to resume duty and free from any disease which might be communicated to the students or others.

 (Countersigned by Principal or Department Head)

 (Signature of Employee)

INSTRUCTIONS: This certificate may be used by employees in place of a medical certificate for an illness of 3 consecutive working days or less and shall be filed on return to duty. Such certificate shall be filed with the principal of the school in which employed or the department head as may be appropriate, who in turn will forward it to the Secretary-Treasurer by the end of the month in which the absence occurred. In case of absences of one-half day, indicate whether a.m. or p.m. This certificate should not be used for an absence longer than 3 days duration.



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A DISABILITY PENSION FOR MEMBERS OF THE SCHOOL DIVISION PENSION FUND (OTHER THAN TEACHERS)

The following is a summary of the General Provisions under By-law 1094 effective April 8, 2002, for disability pensions, and a summary of the conditions affecting any member seeking a disability pension.

1. Eligibility for Disability Pension

A member of the fund is eligible for disability benefits if:

- 1.1 under age 60, an employee is totally or partially disabled, and
- 1.2 has suffered a reduction in employment salary during the last 6 months because of the disability, and
- 1.3 has been under the personal care of a doctor for at least the last 6 months, and
- 1.4 an application for disability pension has been approved by the Pension Fund Committee.

2. Total Disability

- 2.1 A member who is suffering from a physical or mental condition considered to be so severe that during the first 30 months the member is unable to perform the normal duties of his occupation, may be considered to be totally disabled.
- 2.2 A member who after 30 months of disability is unable to engage in any occupation for which the member is reasonably well qualified by education, training or experience may be considered to be totally disabled.

3. Partial Disability

- 3.1 A member who is suffering from a physical or mental condition which is less severe than total disability may be considered to be partially disabled.
- 3.2 The Pension Fund Committee will determine the proportion of partial disability.

4. Application for a Disability Pension

- 4.1 A member who has been off work for three months and who expects to be off work for at least another three months is advised to request the appropriate forms from the Pension Section and apply for a disability pension.
- 4.2 The completed forms are returned to the Pension Fund Committee which may require the applicant to be examined by one or more Medical Practitioners.
- 4.3 When the member's application is approved, the member will submit medical certificates as requested by the Pension Committee.

5. Amount of Benefits Paid on Total Disability

- 5.1 The Disability Income Benefit is up to a maximum of 60% of regular monthly gross earnings at date of disability LESS income from other sources. Benefit is paid monthly.



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6. Amount of Pension Paid on a Partial Disability

- 6.1 A member receives a pension based on total disability multiplied by the proportion of disability.
- 6.2 A member's disability pension proportion is equal to the percentage of the reduction in employment salary during the last 6 months due to the disability, over the earnings the member would have received if no reduction in earnings occurred. Sick leave pay is excluded when determining the reduction in employment salary.
- 6.3 A member who is entitled to a paid-up pension does not receive a pension for partial disability.

7. Adjustments in Disability Pensions

- 7.1 A member will receive an adjusted disability pension when adjustments are made to the salary rate applicable to the member's position.
- 7.2 The minimum or maximum disability pension is adjusted when there is a change in the amount of income used to determine the minimum or maximum pension.

8. Period Disability Pensions are Paid

- 8.1 If an employee has more than 2 but less than 7 years of continuous employment service with the School Division, benefits cease on the earlier of:
- i) 5 years from the date of the first payment
 - ii) age 60
 - iii) the date the employee recovers, or
 - iv) the date the employee dies.
- 8.2 If an employee has more than 7 but less than 10 years of continuous employment service with the School Division, benefits will cease on the earlier of:
- i) 10 years from the date of the first payment
 - ii) age 60
 - iii) the date the employee recovers or
 - iv) the date the employee dies.
- 8.3 If an employee has 10 or more years of continuous employment service with the School Division, benefits will cease on the earlier of:
- i) the end of the month in which the employee reaches 60
 - ii) the date the employee recovers or
 - iii) the date the employee dies.



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8.4 The disability pension will cease if the member refuses to provide the Pension Committee with satisfactory medical evidence of continuing disability.

9. Pension After Age 60

9.1 A member who retires while on Disability Pension will receive a retirement pension in accordance with the provisions of the by-laws under the Pension Plan for Officers and Employees (Other Than Teachers).

9.2 The retirement pension is based on the number of years of service completed prior to retirement. This includes the service during the period the member was receiving a disability pension. For a member receiving a partial disability pension, one year of service will be counted in the same proportion as his partial disability pension percentage.

9.3 Years of service are multiplied by 2% of the average of the member's earnings assumed to have been received for his position, less 0.4% of the member's average earnings for Canada Pension purposes.

In any case, where the provisions of the by-laws under the Pension Plan for Officers and Employees (Other Than Teachers) or the Disability Income Plan for Officers and Employees (Other than Teachers) are more specific, or vary from this general outline, the provisions of the by-law will prevail.



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FORM The
M542 (Can)

Great-West Life
Assurance Company
Long Term Disability Claim Report

Part I Employee's Statement

Instructions: **1. Complete this Part I**
2. Have your Doctor complete form M543, Attending Physician's Statement
3. Return completed forms to your Employer.

Name _____
Address _____
Date of Birth _____ Height _____ Weight _____

When did your present illness begin or injury occur? _____

If injury, where and how did it occur? _____

From what date has your disability continuously prevented you from working? _____

What is the nature of your present disability? _____

Are you now:
House Confined ___ Bed Confined ___ Hospital Confined ___ Ambulatory ___

State briefly your daily routine since leaving work. Mention any light tasks you are able to perform.

Names and addresses of all doctors consulted during present disability

Declaration Re Other Insurance

Important: You are required to complete this declaration before submitting your claim. Are you entitled to benefits for loss of time from work under any other plan such as insurance providing indemnity for accident or sickness, disability income under life insurance, retirement or other plan, Canada Pension Plan, other Government plan, etc?

Yes ___ No ___ If "Yes" enter details below

Name of Company	Policy No.	Monthly Amount	Date Payment Began	Date Payment Will End
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you any other income not mentioned above? Yes 9 No 9 Source _____

I hereby declare that the above information is true and complete. I authorize the release to my insurer of all information requested with respect to my claim.

Date _____ Signature of Employee _____



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LONG TERM DISABILITY CLAIM REPORT

Part II **EMPLOYEE'S STATEMENT**

ALWAYS COMPLETE THIS SECTION IN FULL

1. Name of Employee _____ Social Insurance No. _____
Exemptions for Income Tax purposes: Per TD1 \$ _____ Per TPD1 (for Quebec residents) \$ _____
 2. Group Policy No. _____
 3. Certificate No. _____ Date of full-time employment _____
 4. Effective date of employee's insurance _____ Insurance Class _____
 5. Basic monthly earnings on date of commencement of disability _____
 6. Amount of monthly income for which employee is insured as shown on your records _____
 7. On what date did salary terminate? _____
 8. Date employee last worked? _____
 9. Reason for Leaving _____
 10. If employee has returned to work, give date _____
 11. Is the employee entitled to benefits under Workman's Compensation or similar law in respect of this disability?
Yes No - If "yes", indicate monthly amount and commencement date of benefits _____

 12. If the employee with/without vocational rehabilitation could do less strenuous work on either a full time or reduced time basis, would any such work be available for him in your company? Yes No - If "Yes", please explain:

 13. Please provide a short job description for this employee _____

 14. Remarks: _____

- Date _____ Name of Group _____
Division _____
Authorized Signature _____



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GCBDA-E(5)
DISABILITY COVERAGE
December 8, 1987
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THE GREAT WEST LIFE ASSURANCE COMPANY
ATTENDING PHYSICIAN'S INITIAL LONG-TERM DISABILITY BENEFITS STATEMENT

ATTENDING PHYSICIAN'S INITIAL LONG TERM DISABILITY BENEFITS STATEMENT

Patient's Name _____ Age _____

I hereby authorize the release to my insurer and my policy holder of any information requested in respect of this claim.

Date: _____ Signature of Patient _____

The patient is responsible for the securing of this form and any charge which may be made for its completion.

Attending Physician's Statement of Disability

TO PHYSICIANS - PLEASE NOTE:

This form has been specifically designed with the Physician in mind. By being comprehensive it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and stroke out non-specific areas. In order to help the claimant, sufficient details of History, Investigation, Findings, and Treatment are essential.

This form may be mailed directly to the Insurer or given to the patient at the physician's discretion.

1. History

- (a) When did symptoms first occur or accident happen? Month _____ Day _____ Year _____
- (b) Date total disability commenced. Month _____ Day _____ Year _____
- (c) Has patient ever had same or similar condition? Yes No Unknown

If 'yes' state when and describe.

- (d) Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
- (e) Names of other treating physicians:

2. Diagnosis

- (a) Diagnosis including any complications:
 Primary _____
 Secondary (if applicable) _____
- (b) Subjective symptoms
- (c) Objective findings including results of current x-rays, EKG's or any other special tests.

3. Treatment

- (a) Date of first visit Month _____ Day _____ Year _____
- (b) Date of latest visit Month _____ Day _____ Year _____
- (c) Frequency Weekly Monthly Other (specify) _____
- (d) Is patient following recommended treatment program? Yes No

4. Type of Treatment

- (a) Describe therapy and projected duration of treatment program:

- (b) Date and description of surgery (if applicable) Month _____ Day _____ Year _____

5. Physical Impairment

Is patient Ambulatory House Confined Bed Confined Hospital Confined

If ambulatory and/or house confined, please complete the section below.

- No limitation of functional capacity; capable of strenuous activity
- Minimal limitation of functional capacity; capable of moderate activity
- Medium limitation of functional capacity; capable of light activity
- Severe limitation of functional capacity; incapable fo minimal activity.

Remarks:



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**THE GREAT WEST LIFE ASSURANCE COMPANY
ATTENDING PHYSICIAN'S INITIAL LONG-TERM DISABILITY BENEFITS STATEMENT**

6. Effect of Physical or Mental Impairment on Duties of Job

Please explain the extent to which the patient's illness or injury affects his or her capacity to:

- (a) Perform his or her regular duties _____
- (b) Perform any other occupation comparable with the insurer's condition _____
- (c) If physical movement involved
 - (i) Patient's regular occupation _____
 - (ii) Any other occupation _____

7. Prognosis

- (a) Does disability prevent patient from performing?
- (b) If yes, please indicate when you do expect patient will recover sufficiently to perform duties of

<u>Regular Occupation</u>	<u>Any Other Occupation</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 1 - 3 months <input type="checkbox"/> 3 - 6 months <input type="checkbox"/> Other, please specify _____	<input type="checkbox"/> 1 - 3 months <input type="checkbox"/> 3 - 6 months <input type="checkbox"/> Other, please specify _____
<input type="checkbox"/> Never	<input type="checkbox"/> Never

- (c) If no, please indicate date patient was able to perform duties of

_____	_____	_____	_____	_____	_____	_____
Month	Day	Year	Month	Day	Year	

8. Cardiac (if applicable)

- (a) Functional capacity

<input type="checkbox"/> Class 1 (no limitation)	<input type="checkbox"/> Class 2 (slight limitation)
<input type="checkbox"/> Class 3 (marked limitation)	<input type="checkbox"/> Class 4 (complete limitation)

- (b) Blood Pressure (latest visit) _____
Systolic/Diastolic

9. Visual Impairment

- (a) What was vision at latest observation?

	O.D	O.S
(i) with glasses	_____	_____
(ii) without glasses	_____	_____

- (b) Vision can be restored in whole or in part by

<input type="checkbox"/> O.D.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable
<input type="checkbox"/> O.S	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable

10. Rehabilitation

- (a) Is patient a suitable candidate for trial employment?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Regular Occupation</u>	<u>Any Other Occupation</u>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
- (b) If "yes", when could trial employment commence

<input type="checkbox"/> Full Time	_____
	Day Month Year Day Month Year
<input type="checkbox"/> Part Time	_____
	Day Month Year Day Month Year
- (c) If "no", please explain

- (d) Would vocational counselling and/or retraining be recommended? Yes No

Remarks: _____
Physician's Name (Print) _____

Address _____
Signature _____

Telephone No. _____



EXHIBIT

SUBJECT:

GCBDA-E(6)

NOTIFICATION OF OCCUPATIONAL ILLNESS

APPROVAL DATE:

December 8, 1987

REVISION DATE:

November 3, 2003, August 25, 2008

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The Winnipeg School Division

Employee Accident Report

PART A - EMPLOYEE INFORMATION

Name: _____ Home Phone No. _____
 Address: _____ Postal Code: _____
 Home School _____ Position: _____
 Date of Birth: Day _____ Month _____ Year _____ S.I.N. _____

ACCIDENT DATA

Location Where Accident Occurred _____

Date and Time of Accident: Day _____ Month _____ Year _____ at _____ a.m. p.m.

To Whom Reported _____ Position: _____

Date and Time Reported to Principal/Administrator: Day _____ Month _____ Year _____ at _____ a.m. p.m.

Describe what happened to cause the injury, stating all injuries and indicating right or left:

Witnesses to accident:

1) _____ 2): _____

Name of hospital, if any, where treatment was received: _____

Full name and address of attending doctor:

Was first aid given? If so, by whom?

Employee's Signature _____

Date _____

PART B - IMMEDIATE SUPERVISOR INFORMATION

Time Lost? Yes No If yes, please complete the following:

Date and hour last worked following the accident: Day _____ Month _____ year _____

Time _____ a.m. p.m.

Has the worker returned to work? Yes No

When? Date: Day _____ Month _____ Year _____ Time _____ a.m. p.m.

Signature of Immediate Supervisor _____

Position _____ Date _____

PART C - PRINCIPAL/ADMINISTRATOR/MANAGER

Signature of Principal/Administrator/Manager _____

Position _____ Date _____



EXHIBIT
SUBJECT:

GCBDA-E(7)
NOTIFICATION OF OCCUPATIONAL
ILLNESS/INJURY

APPROVAL DATE:
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Supervisor's/Administrator's Report of Accident Investigation

To be completed within 24 hours of accident

Employee's Name _____ Job Title _____
Please print

Date of Accident: _____ Time of Accident: ____:____AM ____:____PM
Day Month Year

Date Reported to Supervisor/Administrator: _____ Time Reported: ____:____AM ____:____PM
Day Month Year

Location of Accident: _____

Describe the injury/illness and/or any property damage:

Is this a lost time accident? Yes No

Witness Name(s): _____

Were witnesses interviewed? Yes No
If "yes", do witnesses confirm worker's statement Yes No

Describe clearly how the accident occurred:

What acts, failures to act and/or conditions contributed to this accident? What are the root causes?

What action has or will be taken to prevent recurrence?

Supervisor/Administrator Signature: _____ Date: _____



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GCBDA-E(8)
SICK LEAVE/DISABILITY COVERAGE
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Authorization for Release of Medical Information

To be filled out by employee to authorize the release of medical information to the Human Resources Department of The Winnipeg School Division.

I hereby authorize _____ to release all medical information including diagnostic, treatment, prognosis and other related medical information pertaining to myself for the current medical condition indicated below.

Doctor's Name (please print)

_____ Medical condition/purpose of record release: _____

Recipient of medical information to be released:

The Winnipeg School Division
Human Resources Department
1577 Wall Street E.
Winnipeg, Manitoba
R3E 2S5
Phone: 789-0492 Fax: 784-9633

Employee Statement of Consent:

Employee Name (please print)

Employee Signature

Date

Witnessed by



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SICK LEAVE/DISABILITY COVERAGE
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The Winnipeg School Division Capabilities Assessment Initial Reassessment
 An assessment of any significant reduction in functional abilities due to injury, illness or pregnancy

A. To be completed by Wellness Department (Please Print)				
Surname	First Name	<input type="checkbox"/> Work Related/ <input type="checkbox"/> Illness	<input type="checkbox"/> Non-Work Related/ <input type="checkbox"/> Pregnancy	Employee #
Work Location	Job Title	Date of Injury/Illness	Absence Commenced	Office Use Only
Supervisor's Name	Telephone Nbr.			

B. Overall Assessment of Employee's Functional Limitation(s) (to be completed by treating physician)
 Due to this injury, illness or pregnancy, this employee has → Functional Limitation(s) Complete C & D
 No Functional Limitation(s) (Fit for regular duties, Complete E)
NOTE: "Occasionally defined as no more than 33% of a working day"

C. Functional Limitation(s) (To be completed by the treating physician - Please Estimate)				
Indicate the location of problem (circle)	Check any limitation(s)	Indicate Limitation(s) include in space provided		
Step 1	Step 2	Step 3		
A. Systemic or Non-Physical	Walk	Duration 4 2 1 1/2 hrs Short Distances	No walking	
B. Head Inc. vision/hearing/speech	Stand	Duration 2 1 1/2 1/4 hrs < 1/4 hr	No standing	
C. Neck	Sit	Duration 2 1 1/2 1/4 hrs < 1/4 hr	No sitting	
D. Upper back/chest/abdomen	Lift/Carry	Occasionally Weight in lb.	Comments	
E. Lower back	Floor - waist	50 25 10 <5	_____	
F. Lower abdomen	Waist - shoulder	50 25 10 <5	_____	
G. Shoulder or upper arm (R or L) Above shoulder	Above shoulder	50 25 10 <5	_____	
H. Elbow or lower arm (R or L)	Bend/turn	Occasionally Unable	Comments _____	
I. Wrist or hand (R or L)	Head - neck	_____	_____	
J. Hip or upper leg (R or L)	Back - waist	_____	_____	
K. Knee or lower leg (R or L)	Push/pull (cart/trolley)	Occasionally Unable	Comments _____	
L. Ankle or foot (R or L)	Moderate load	_____	_____	
	Light load	_____	_____	
	Climb	Occasionally Unable	Comments _____	
	Flight of stairs	_____	_____	
	Few steps	_____	_____	
	Reach	Occasionally Unable	Comments _____	
	Above shoulder	L / R L / R	_____	
	Below shoulder	L / R L / R	_____	
	Use hands for	Occasionally Unable	Comments _____	
	Writing	L / R L / R	_____	
	Typing/data entry L / R	L / R	_____	
	Fine manipulation L / R	L / R	_____	
	Simple grasping	L / R L / R	_____	
	Sensory (Circle)	Sight Hearing Speech Balance Other	_____	
	(Specify)	_____	_____	
	Operate Equipment	_____	_____	
	Hours of Work	_____	_____	

NO DIAGNOSIS OR TREATMENT

D. Physician's Assessment (Please complete and sign)
 Note: WSD will strive to find modified/alternate duties to match the limitation(s) identified. Information will assist in determining if suitable modified and/or alternate duties can be provided.

Please estimate when this employee can begin working within the above noted limitation(s). Immediately or After _____ days Other: _____

In what period can recovery of usual functional abilities be anticipated? 1 - 3 days 4 - 7 days 8 - 14 days 15-28 days 1 - 2 months 2 - 3 months Over 3 months

Note: Employees not yet medically fit for regular duties will require periodic reassessments. If you have scheduled a reassessment for this employee, please indicate date: _____ (DD MM YY)

E. Physician's Name & Address _____ **(Signature)** _____ **(Tel. No.)** _____ **(Date)** _____