



Disability Employee Guidebook

Please refer to this book for any of the following:

- Weekly Indemnity / Short Term Disability
 - Return to Work Planning
 - Modified Work Centre

Table of Contents

WEEKLY INDEMNITY / SHORT TERM DISABILITY **SECTION 1**

FREQUENTLY ASKED QUESTIONS
SUN LIFE SHORT TERM DISABILITY CLAIM GUIDE
HOW TO SET UP DIRECT DEPOSIT PAYMENTS
USW AUTHORIZATION FOR RELEASE OF INFORMATION
PLAN MEMBER'S STATEMENT CLAIM FOR DISABILITY BENEFITS
ATTENDING PHYSICIAN'S STATEMENT DISABILITY CLAIM

EXTENSION OF CLAIMS **SECTION 2**

CONTINUING CLAIM FOR SHORT-TERM DISABILITY FORM

RETURNING TO WORK **SECTION 3**

RETURN TO WORK/STAY AT WORK/MEDICAL FORM

MODIFIED WORK CENTRE **SECTION 4**

PHYSICIAN'S LETTER – MODIFIED DUTIES

RESOURCES **SECTION 5**

DISABILITY ROADMAP AND THE DUTY TO ACCOMMODATE/NOTES/APPENDIX
MENTAL HEALTH RESOURCES

CONTACTS **SECTION 6**

Weekly Indemnity / Short Term Disability Claim Check List for Employees

Documents needed to initiate a claim:

1.	Plan Member's Statement	
2.	Direct Deposit Information	
3.	Attending Physician's Statement	
4.	Plan Sponsor's Statement (no employee action required)	
5.	USW Authorization for Release of Information (optional)	

Important information about these documents:

Plan Member's Statement – provides information about your condition, how it occurred, your medical history and your income/benefits while you are on leave. Please ensure that you have signed and dated this form and that it includes all relevant medical appointments and dates.

Direct Deposit – Once your claim has been approved, Sun Life will mail a cheque to your address noted on your paperwork. If you would like to be set up for direct deposit please include a void cheque or official banking information.

Attending Physician's Statement – completed by your Attending Physician, walk-in clinic Physician, Specialist, Surgeon, etc.; provides specific medical information about your condition (diagnosis and prognosis) and your expected recovery. Please include any medical documentation from other relevant appointments as well as ensure that you have completed Section 1 – "Plan Member information and authorization to be completed by patient".

Plan Sponsor's Statement – Completed by your employer.

USW Authorization for Release of information – allows the release of any and all information relating to your Weekly Indemnity (Short Term Disability) claim to the United Steelworkers, and its representatives.

If you have any questions, please do not hesitate to contact:

Brittany Carvath	250.523.3286	Brittany.Carvath@teck.com
Theresa Tourand	250.828.2860	admin@usw7619.com

Table of Contents

WEEKLY INDEMNITY / SHORT TERM DISABILITY **SECTION 1**

FREQUENTLY ASKED QUESTIONS
SUN LIFE SHORT TERM DISABILITY CLAIM GUIDE
HOW TO SET UP DIRECT DEPOSIT PAYMENTS
USW AUTHORIZATION FOR RELEASE OF INFORMATION
PLAN MEMBER'S STATEMENT CLAIM FOR DISABILITY BENEFITS
ATTENDING PHYSICIAN'S STATEMENT DISABILITY CLAIM

EXTENSION OF CLAIMS **SECTION 2**

CONTINUING CLAIM FOR SHORT-TERM DISABILITY FORM

RETURNING TO WORK **SECTION 3**

RETURN TO WORK/STAY AT WORK/MEDICAL FORM

MODIFIED WORK CENTRE **SECTION 4**

PHYSICIAN'S LETTER – MODIFIED DUTIES

RESOURCES **SECTION 5**

DISABILITY ROADMAP AND THE DUTY TO ACCOMMODATE/NOTES/APPENDIX
MENTAL HEALTH RESOURCES

CONTACTS **SECTION 6**

Weekly Indemnity / Short Term Disability Claim Frequently Asked Questions

What is my Plan Member ID #?

This is your payroll number

What does “Plan Sponsor” mean?

This is another term for “employer”

How much will my benefits be?

Benefits are \$850.00 (before deductions) per calendar week

How long will I receive disability payments?

You will be eligible to receive payments as long as you meet the definition of being “totally disabled”, by your Attending Physician, from your own occupation, up to the maximum of 52 weeks (after which you would be assessed for long-term disability benefits). This may also include requirements of pursuing appropriate treatment or attempting modified duties.

What is expected of me while I am off work?

Sun Life and your employer expect that you will return to work as soon as it is safe and healthy to do so, which includes considering any reasonable offer of modified work with your employer. Sun Life will also require you to obtain periodic medical updates to determine your level of total disability and continued eligibility of benefits.

When do benefit payments begin?

- **Illness:** You will become eligible for benefits the first day you consult a Physician, or after 2 days of total disability, whichever is later.
- **Accident:** You will become eligible on the date you become totally disabled or the date you first see a Physician, whichever is later.
- **Please note:** The 2 day waiting period may be applicable for scheduled day surgery.

What is the purpose of the Return to Work form?

The “Return to Work/ Stay at Work/Medical” form is an exclusive Teck Highland Valley Copper medical document, and will not be accepted by Sun Life. Please see the “Information for Employees” section on the backside of the form for more details.



Short-Term Disability

Claim Guide

Short-Term Disability (STD) coverage provides benefits to you when you are disabled. This guide is designed to help you through the claim submission process and to answer any initial questions you may have with respect to filing a claim for Short-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.



When we receive your claim. Your Case Manager reviews all the information received about your claim and the contract provisions. As part of this review, they look at:

- the medical information
- the impact your condition has on your ability to function and carry on your daily activities
- your occupational duties
- how your condition affects your ability to perform your occupation

As part of this review, your case manager may contact you by phone to discuss your claim. They may have some questions for you to better understand your condition, but this is also an opportunity for you to ask them any questions you may have about your claim. They may also need to contact your doctor and/or employer to ask some further questions or to obtain any missing information.



We'll let you know. The claims assessment process usually takes 5 business days after we receive all the necessary information. If your claim is approved based on your employer's STD plan, your case manager will notify you and your employer in writing. If your claim is not approved, your case manager will notify you in writing and provide the reasons for the decision.

For some claims, we may determine that we don't have enough information to make an informed decision.



Your information is confidential. We treat the information you provide to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's Statement, or as permitted or required by law.



Reporting your absence

To apply for STD benefits, you and your employer will need to send us a completed STD form package. The package contains three forms:

- A Plan Sponsor's Statement, which your employer completes and sends to us separately;
- A Plan Member's Statement, which you must complete and return to our office.
- An Attending Physician's Statement, which you take to your doctor to complete.

NOTE: Your doctor may charge you a fee to complete this form. If so, you will be responsible for paying that fee.

Complete the Plan Member's Statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence.
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Provide the required document outlined in the "Automatic deposit of your disability payments" section if you would like to have your payments deposited into your bank account. For chequing accounts, we will require a personalized VOID cheque.
- Read and sign the Authorization which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. Also, please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.

Have your physician complete the Attending Physician's Statement

This statement provides us with specific medical information about your condition and your expected recovery.

- The Attending Physician's Statement must include all the information requested about your condition. This form can be completed by your family doctor, a doctor at a walk-in clinic, a specialist or nurse practitioner - any medical professional who is a doctor of medicine and that has treated you for your condition.
- If your doctor has conducted tests, a copy of the findings must be included with the Statement.
- If you have seen a specialist for your condition, be sure to have your doctor send us copies of all consultation and clinical notes with the Statement.

NOTE: Do not change or write anything on the Attending Physician's Statement. Any changes to the Statement must be initialed by your doctor.

Sending in your forms

- Follow up with your doctor (if the form was left with them for completion) and employer to confirm they have completed, signed and submitted their forms to our office.
- We recommend you submit the completed claim forms as soon as possible after the beginning of your absence, as most contracts limit the period of time in which to submit a claim.
- Send in your forms using one of the options provided on the last page of the Plan Member Statement.

Be sure your group Contract number and your Member ID number are clearly shown on your Plan Member's Statement and Attending Physician's Statement before submitting the forms to us.

If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.



FAQs

We want you to feel comfortable with the Short-Term Disability claims process. This Frequently Asked Questions guide is designed to help you understand more about the process, from claims submission through to your recovery.

What does plan sponsor mean? The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your plan.

What are my Contract and Member ID numbers? The Contract number refers to the document that outlines your plan sponsor/employers benefits plan with Sun Life Financial. The Member ID is the number used to identify you specifically. These numbers can be found on your coverage or enrollment summary or in your employee benefits booklet.

Why does my doctor need to fill out the Attending Physician's Statement? The Attending Physician's Statement has been designed to ask your doctor for information that will help us understand the nature of your condition and how it impacts your functional abilities. If your doctor provides only part of the information requested, or a brief note on a doctor's prescription pad, we may not have all the information needed to assess your request for benefits. This will potentially delay a decision on your claim.

How are my benefits calculated? Disability benefit payments are usually based on a specific percentage of your weekly earnings at the time you become disabled. The benefit amount under your plan is specified in your employee benefits booklet.

If my claim is approved, when do my payments start? Your disability benefit payments will be paid from the day following the completion of the elimination period. The elimination period is outlined in your employee benefits booklet. If this date is in the past, then payment will be made back to this date, for the retroactive amount owing.

How and when are payments made once the claim is approved? If you would like to have your benefits deposited directly into your bank account, the Plan Member's Statement outlines what information is needed in order to set this up - see *Automatic deposit of your disability payments*. Don't forget to review this section and provide the required documentation. For chequing accounts, we will require a personalized VOID cheque. NOTE: There may be a delay in payment if a scheduled payment falls on a holiday.

How long will I receive disability payments? For STD, you will continue to receive disability benefit payments as long as you meet the definition of total disability. Usually, this means you are 'totally disabled' for your own occupation up to the maximum benefit period. The definition of total disability and the maximum benefit period for your plan are defined in your employee benefits booklet. There are also other requirements you must meet in order to continue to receive disability benefit payments. These include continuing to explore new employment opportunities, pursuing appropriate treatment or attempting modified work duties. Please consult your employee benefits booklet for the specific details of your plan.

What are my responsibilities while I receive disability benefits? While you are in receipt of disability benefits, we will talk to you about returning to work, at the appropriate time. We expect that you will participate in these discussions, and return to your own occupation as soon as it is safe and healthy for you to do so. If it becomes apparent that you will not be able to return to your own occupation, you will be expected to consider any reasonable offer of modified work with your employer.

Once I've been approved for benefits, how often is medical information requested? A clear understanding of the progress of your recovery is considered essential in preparing for a potential return to work. Periodic updates on your medical condition and functional status help us determine your progress. The frequency of status reports will be determined by the unique circumstances of your claim, your medical condition and treatment plan. We will follow up with you and your treating doctor(s) by telephone or mail. Your Case Manager will work with your doctor and Sun Life's Health Partners to ensure you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam to get more information. We will arrange the appointment and give you adequate advance notice. (We will provide a copy of the results to your treating doctor.)

When would benefits not be paid? Benefits may not be paid if you:

- are not considered totally disabled
- are not receiving or following appropriate treatment as recommended by your treating doctor
- are not participating in a Sun Life-approved rehabilitation program
- are on leave of absence, strike or lay-off, except where Sun Life specifically agreed to the continuation of coverage or as required by law
- are absent from Canada due to any reason, unless you have received written agreement from our Case Manager in advance to pay benefits during this period
- complete any work for wage or profit except as approved by us
- serve a prison sentence or are confined in a similar institution

Please consult your employee benefits booklet for the specific details of your plan.

What if I receive income from another source? How will that impact my benefit? Your employer's STD plan may indicate that your disability benefit payments are reduced by payments received from other sources, such as Canada Pension Plan (CPP), Quebec Pension Plan (QPP) and Workers' Compensation for the same or subsequent disability. Your benefit payment will not be reduced by income you receive from an individual disability plan. A retroactive award from another source may reduce your disability benefit payments and may result in an overpayment. If this situation occurs, you are expected to reimburse the amount overpaid.

What if I return to work with some restrictions? Your Case Manager will work with you and your employer to develop a return-to-work plan that accommodates what you are able to do. Your return-to-work plan could include, for example, a gradual increase in hours and/or modified duties. Should your return to work require specific vocational expertise, we may involve one of our Health Management Consultants to assist with planning your return to the workplace. We will contact your doctor to ensure he or she is aware of the plan before it begins. Once you're back performing the essential duties of your occupation, full-time, Sun Life is usually no longer involved.

What happens if I'm unable to return to work before the maximum benefit period? If your absence is anticipated to extend beyond the maximum benefit period provided under your employer's STD plan, and you have LTD coverage with us we will rely on the medical information gathered during the management of your STD claim to make a decision on your entitlement to Long Term Disability benefits. Your Case Manager will provide you with further information at that time.

Will I receive a tax slip? A tax slip will be issued if the disability benefit payments you receive are taxable income. Tax slips are mailed by the end of February every year, for the previous tax year. If you are unsure if the disability benefits payments you receive are taxable income, please contact your Benefits Administrator.

* This guide is not intended to replace or amend your employee benefits booklet. If there are any discrepancies between your employee benefits booklet and the information in this guide, the group benefits booklet will take priority.

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than five million people in over 10,000 corporate, association, affinity and creditor groups across Canada. Our core values — integrity, service excellence, customer focus and building value — are at the heart of who we are and how we do business.

Our extensive products, services and technology enable us to tailor group benefit programs to meet virtually any customer's needs competitively and cost effectively.

Sun Life Financial and its partners have operations in key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies. PDF8006-E-04-18 ml-cc



AVOID MAIL DELIVERY DELAYS AFFECTING YOUR
DISABILITY PAYMENT WITH

DIRECT DEPOSIT TO YOUR BANK ACCOUNT.

SIGN UP TO GET YOUR DISABILITY PAYMENTS
DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT
BY ELECTRONIC FUND TRANSFER (EFT).

IT MAKES SO MUCH SENSE!

- Payments are deposited automatically – no uncertainty about mail schedule or possible disruption due to postal strike
- Payments can't be lost or stolen
- Eliminates the need to go to the bank to deposit a cheque

3 EASY STEPS TO SIGN UP



1. Write '**VOID**' on the front of a personalized cheque, with your name pre-printed on it.



2. Write your **POLICY NUMBER** and **CLAIM CONTROL NUMBER** on the cheque.



3. **MAIL** the cheque to us in the enclosed pre-addressed postage paid envelope, or **FAX** to the number below.

If you do not have a chequing account, please provide a direct deposit form or bank verification statement from your bank branch.

A few things to note:

- If the form is completed manually by your bank, trust company, caisse populaire or credit union in Canada, it must be signed and/or stamped by a banking representative.
- If your bank provides an on-line direct deposit form, pre-populated with your banking information, this can also be submitted.
- These forms must contain your name, claim control number, bank number, branch number and account number.

You can **FAX** your VOID cheque or the other acceptable documents listed above to the following Sun Life Financial Disability offices:

- If you live in the Atlantic provinces, Quebec or Ottawa: 1-866-639-7846
- For all other provinces or territories: 1-866-209-7215

Alternatively, you can **MAIL** the information using the enclosed pre-addressed envelope.

If you have any questions, please contact our customer service area.
If you live in the Atlantic provinces, Quebec or Ottawa: 1-800-361-2128.
For all other provinces or territories: 1-800-361-6212.

LIFE'S BRIGHTER *under the sun*



HOW TO SET UP DIRECT DEPOSIT

WEEKLY INDEMNITY PAYMENTS WILL BE ISSUED AS A CHEQUE AND RECEIVED IN THE MAIL UNLESS YOU SET UP DIRECT DEPOSIT. IN ORDER TO BE SET UP FOR DIRECT DEPOSIT YOU WILL NEED TO INCLUDE ONE OF THE FOLLOWING:

- VOID CHEQUE

YOUR NAME
678 Main Street
Anywhere, MI 12345

DATE _____ 123

PAY TO THE ORDER OF _____ \$ _____

_____ DOLLARS

123456789 00123456789 123

Routing Number Account Number Check Number

- OFFICIAL BANKING INFORMATION

TD Canada Trust How to Set up Direct Deposits or Pre-Authorized Debits

Customer Name

Your Name _____

Transit No.

8 8 8 8 8 8

Inst. No.

0 0 4

Account No.

8 8 8 8 8 8 8 8



Use the account details provided to set up Direct Deposits and Pre-Authorized Debit Payments.

Direct Deposit

Direct Deposit is the most convenient way to receive recurring deposits (i.e. pay, pension, government payments, annuity, interest, etc.) with immediate access to funds. There are no holds on your funds or a need for special trips to your local branch or ATM to deposit your cheques.

To set up a Direct Deposit with the federal government:

1. Visit www.directdeposit.gc.ca for a Government of Canada Direct Deposit enrolment form and use your account information from the fields above when completing the form.
2. If you do not have a cheque to void, have your local TD Canada Trust branch stamp the enrolment form.
3. Once complete, mail the enrolment form to the address provided.

Note: Additional information may be required on the form such as your Social Insurance Number or date of birth. The form includes a toll free number for support with completing the form.

To set up a Direct Deposit with your employer:

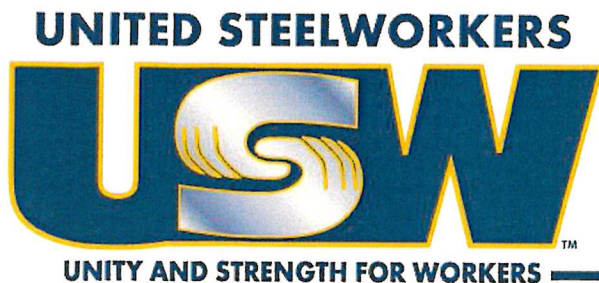
1. Provide your account information from the fields above to the payroll department of your employer or company pension provider.

Pre-Authorized Debit (PAD)

A Pre-Authorized Debit (PAD) is an automatic withdrawal taken directly from your TD Canada Trust account by a company or

THE DOCUMENT WILL NEED TO INCLUDE YOUR NAME, BANK NUMBER, BRANCH NUMBER AND ACCOUNT NUMBER. IF POSSIBLE, PLEASE ALSO NOTE YOUR EMPLOYEE NUMBER.

THIS CAN BE SUBMITTED AT THE SAME TIME AS YOUR INITIAL PAPERWORK



AUTHORIZATION

Short Term Disability

To Whom It May Concern

Employee's Name: _____

Employee #: _____

I, _____ hereby authorize the release
and all medical, Short-Term Disability, legal and appeal related information,
documents or opinions regarding my Weekly Indemnity (Short Term
Disability) Claim(s) or appeals(s) to my Union, United Steelworkers Local
7619, and its representatives.

Print Name: _____

Signature: _____

Dated: _____

UNITED STEELWORKERS 7619

770 Victoria Street, Kamloops, BC V2C 2B6 250.828.2860 Fax: 250.828.2950 uswa7619@telus.net

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

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.

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.

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.

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.

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

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)

Date (dd-mm-yyyy)

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.

Date (dd-mm-yyyy)

Date (dd-mm-yyyy)

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
-------------------	------	----------

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

Date (dd-mm-yyyy)

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. 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.

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
--	--	--	---	---	--

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)
-------------------------	-------------------

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.

Diagnosis

Primary:

Secondary:

If childbirth: expected or actual delivery date (dd-mm-yyyy) ☐ Vaginal
☐ C-Section

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

Start dates of current work absence

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)

NOTE: Your patient is responsible for any charge made for the completion of this form.



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

CONTINUATION OF CLAIMS

The decision to extend the duration of your Short-Term Disability claim is decided directly by Sun Life Financial. Please refer to the guidance provided in your approval letter.

Sun Life Contact Information:

Sun Life Assurance Company of Canada Group Disability Management Office

PO Box 48810 Stn Bentall

Vancouver, BC V7X 1A6

Fax: 1-866-639-7829

Phone: 1-866-246-4153

Email: disabilityclaims@sunlife.com

Frequently Asked Questions:

How long will an extension take to process?

Each disability claim process is managed on a case by case basis, so it is highly recommended to submit the additional paperwork as soon as possible to avoid any delay.

What if Sun Life denies my extension?

If Sun Life denies the extension of your claim you can choose to appeal the decision by submitting additional paperwork. Your case manager will be able to provide you with instructions.

Do I have to stay off work until the end of my extension?

No. If you feel your condition has improved and you would like to return to work, please have a medical practitioner complete a Return to Work form and forward it to Human Resources. To prevent any over payment from Sun Life, it is important that you contact your case manager to let them know you are returning to work.

Continuing Claim for Short-Term Disability - Attending Physician's Statement of Disability



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

Please print clearly in ink

To be completed by the patient/claimant

Member's Name _____ Date of birth: _____
First and last name (Quebec residents - maiden name) Day Month Year

Policy/Contract No. _____ Division _____ Member ID _____ Control No. _____

AUTHORIZATION: I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Patient/Claimant's signature _____ Date _____
Day Month Year

Note: The patient is responsible for obtaining this form and for any charges for its completion.

To be completed by the physician

If you have completed this form before, please report on only new or different information dating from your last report.

Diagnosis:

1. Primary: _____ Symptoms: _____
2. Secondary: _____ Symptoms: _____
3. Other contributing factors/complications: _____

History:

1. Symptoms began or accident happened on _____ 2. Illness or injury forced cessation of work on _____
Day Month Year Day Month Year
3. First visit _____ 4. Is this a work-related illness/injury? ☐ No ☐ Yes ☐ Unknown
Day Month Year
5. a) Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown
- b) If yes, state when and describe condition _____

6. Has your patient been hospitalized ☐ Yes ☐ No
- If yes, please indicate dates _____ to _____ Name of Hospital _____
Day Month Year Day Month Year

Current findings

1. When did you most recently examine your patient? _____
Day Month Year
2. What were your findings on this examination date? _____

3. Is your patient: a) Diabetic ☐ Yes ☐ No Insulin dependent ☐ Yes ☐ No
- b) Smoker ☐ Yes ☐ No
- c) Weight _____ Height _____ In a weight reduction program? ☐ Yes ☐ No
- d) ☐ Right handed ☐ Left handed (if applicable to illness/injury)
- e) Is the patient receiving or in need of treatment for alcohol or drugs? ☐ Yes ☐ No
- If yes, please elaborate on treatment _____
- f) Is the patient prevented from driving because of a medical condition ☐ Yes ☐ No
4. What functional limitations affect the claimant's ability to perform his/her normal activities, including work? _____

Was any formal testing done i.e. Functional Abilities Evaluation? If so, please enclose the report and date of the examination. _____

5. What investigations have been done? Please list specific tests below and attach copies of test results.

Tests done (e.g., EKG's, x-rays, lab tests)	Date performed			Summary of results (Attach copies of all available reports.)
	Day	Month	Year	

Treatment

1. I see this patient ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other _____

I am providing: ☐ Primary care ☐ Consultant care or ☐ Both

2. Identify the current medications and dosages prescribed as well as the response to these medications. _____

3. Therapy? ☐ Yes ☐ No If "Yes", indicate type (e.g. physiotherapy, psychotherapy, pain therapy etc.) _____

Frequency: ☐ Daily ☐ _____ x per Week ☐ Other _____

At: ☐ Outpatient dept. ☐ Therapist's ☐ Home

4. Surgery? ☐ Yes ☐ No If "Yes", type of surgery _____

date ☐ performed ☐ planned

Day	Month	Year			

5. Any other treatment or future plans for treatment? (Specify with dates.) _____

6. Summarize patient's response to treatment _____

Has your patient been referred to any other physician(s)/specialist(s)? ☐ Yes ☐ No If yes, complete the following chart and attach a copy of the report.

Physician's name and specialty	Date of examination			Findings
	Day	Month	Year	

Prognosis

Have you discussed a return to work plan with your patient? ☐ Yes ☐ No If no, why not? _____

If yes, please provide details about the return to work plan, including approximate time frames. _____

Notice to physician

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the patient and/or those authorized by him/her to receive such disclosure unless you notify us 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.

Physician's signature _____

Date

Day	Month	Year			

Print name _____ Phone number () _____

Return this form to your patient or send the form to Sun Life Assurance Company of Canada Disability Benefits office. If you fax or mail this form to Sun Life Assurance Company of Canada, please confirm the appropriate Disability Benefits office with your patient. Thank you for your assistance.

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

1100 - 1809 Barrington St.

Halifax NS B3J 3K8

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

RETURNING TO WORK

RETURNING TO WORK – Weekly Indemnity / Short Term Disability

When you are ready to return to work (regular or modified duties) please visit your Attending Physician for the completion of a 'Return to Work / Medical Form' (obtained from your employer). To facilitate an efficient and appropriate return, please ensure this form is forwarded to Human Resources as soon as possible **before** you return to work.

RETURNING TO WORK – Workers' Compensation (WorkSafeBC)

When seeking medical attention due to an occupational injury / illness. It is expected that you will discuss a return to either regular or modified duties with the Medical Practitioner. If there are any limitations / restrictions, the completion of a "Return to Work Form" by the Medical Practitioner is required. The USW has trained representatives that are available to assist you when requested. You are encouraged to reach out to your representative early in your injury/illness.

IMPORTANT INFORMATION REGARDING THE RETURN TO WORK FORM

A Physician's report will normally be required if an employee has been absent from work for any of the following reasons:

- Suffered any workplace compensable injury
- Suffered any back injury
- Suffered from any medical problems which required hospitalization and/or surgery
- Been confined with any contagious disease
- Been absent for medical reasons for which documentation is requested
- Been required under the Attendance Management Policy to produce an appropriately dated Physician's report
- If requested by your immediate Supervisor and/or Superintendent
- Has an unresolved medical condition or prescription medication that may affect safety
- Requires modified duties

The Physician's report can consist of one or both of the following:

- A Physician's note indicating the exact return to work date, a list of limitations and the duration of these limitations (if applicable) and an indication of a return to regular duties or modified duties
- Completion of Teck Highland Valley Copper Partnership's Return to Work Form which can be obtained through Human Resources.

Please note that a Physician's report or a RTW Form should be completed when an employee is ready to return to work, but a RTW Form can also be used as medical documentation to support your absence when an update is needed. Any fees associated with the completion of a Physician's report or a RTW Form should be forwarded to Human Resources for payment or reimbursement.

In any of the instances listed above, the employee must contact Human Resources and be cleared by Human Resources before reporting to regular or modified duties. This is to ensure that a thorough assessment of the employee's capabilities and/or limitations can be achieved, thereby increasing the likelihood of a successful return to productive employment for both the employee and the Company.

****MOST IMPORTANTLY****

The Return to Work form is not accepted by Sun Life as medical documentation.

RETURN TO WORK / STAY AT WORK / MEDICAL FORM

(Strictly Confidential)

Phone: (250) 523-3300 (Occupational) or (250) 523-3226 (Non-Occupational) Fax: (250) 523-3367

NOTE: This Document will not be accepted by Sunlife as medical documentation
For assistance please contact HR Coordinator: Brittany Carvath (Brittany.Carvath@teck.com / 250.523.3286)

SECTION A: (To be completed by employee)

EMPLOYEE NAME (please print)	EMPLOYEE NUMBER
EMPLOYEE SIGNATURE	DATE
By my signature, I authorize TECK HVC PARTNERSHIP to contact my Attending Physician with regards to the information on this form.	

SECTION B: (To be discussed with patient and completed by Physician)

Date of first visit for present period of sickness / absence: DAY: _____ MONTH: _____ YEAR: _____		
ABSENCE DUE TO:	<u>NON-OCCUPATIONAL</u>	<u>OCCUPATIONAL</u>
	<input type="checkbox"/> INJURY / ILLNESS	<input type="checkbox"/> INJURY / ILLNESS
Patient's prognosis: _____		
Currently prescribed medications which may affect ability to work or operate machinery: _____		

RETURN TO WORK STATUS:	RETURN TO WORK DATE: _____
<input type="checkbox"/> REGULAR DUTY	
<input type="checkbox"/> MODIFIED DUTY (as described below)	

SECTION C: Patient is <u>NOT</u> capable of:	<u>COMMENTS</u>
Completion of this section will enable us to facilitate the employee's safe return to work. Where necessary, please expand on restrictions listed.	
<input type="checkbox"/> Standing:	_____
<input type="checkbox"/> Sitting:	_____
<input type="checkbox"/> Walking: Flat Ground	_____
<input type="checkbox"/> Walking: Uneven Ground	_____
<input type="checkbox"/> Repetitive use of injured area:	_____
<input type="checkbox"/> Repetitive bending:	_____
<input type="checkbox"/> Lifting: (Max. Wt.)	_____
<input type="checkbox"/> Carrying: (Max. Wt.)	_____
<input type="checkbox"/> Pushing: (Max. Wt.)	_____
<input type="checkbox"/> Pulling: (Max. Wt.)	_____
<input type="checkbox"/> Climbing ladders:	_____
<input type="checkbox"/> Using stairs:	_____
<input type="checkbox"/> Working at heights:	_____
<input type="checkbox"/> Exposure of Injury: To Heat: <input type="checkbox"/>	_____
	To Cold: <input type="checkbox"/>
	To Dust: <input type="checkbox"/>
	To Wet: <input type="checkbox"/>
<input type="checkbox"/> Operation of heavy equipment:	_____
<input type="checkbox"/> Operation of motor vehicle:	_____

Limitations / Restrictions in effect until: _____

Follow up appointment: None required ☐ Date of Next Appointment: _____

_____ PHYSICIAN'S NAME (PLEASE PRINT)	_____ DATE:
_____ SIGNATURE OF ATTENDING PHYSICIAN	_____ TELEPHONE NUMBER:

MODIFIED WORK CENTRE (MWC)

Resources

Members of the Disability Management Team and the Disability Management Committee are available to assist with an employee's return to work. Limited medical supplies (i.e. braces, supports, bandages) are available as well as a rehabilitation room containing exercise equipment (i.e. treadmills, bikes, weights) and rubber flooring / mats, allowing employees to do rehabilitation exercises.

Essential Job Demands

Temporary accommodations are available to all but the totally disabled. As such, the only job demand is that the employee be able to participate in suitable and productive work.

Tasks Available

Modified tasks, which require no technical or special skills to perform, are primarily sedentary in nature and involve limited to no walking on uneven ground, no heavy lifting / carrying / pushing / pulling or climbing of ladders or stairs.

Schedule

The Centre operates Monday to Thursday 7:00 am to 5:00 pm. A graduated work week / hours are available, as well as a gradual increase in hours as the employee returns to their regular department.

Safety Concerns

The Modified Work Centre is kept as dust free and dry as possible (contains a heating system). In addition to a level entry and egress, the Centre has a hard (concrete) level walking surface and no stairs (for those requiring a walking aid). The Centre also has a "PPE Free" area for those unable to wear Personal Protective Equipment (i.e. hard hat, safety glasses, steel toed boots)

If you have any questions, please do not hesitate to contact:

Bruce Halliburton – Modified Work Centre Supervisor	250.523.3300	Bruce.Halliburton@teck.com
Brittany Carvath – Human Resources Coordinator	250.523.3286	Brittany.Carvath@teck.com

Task Examples:

Administrative:	Photocopying/ <u>Scanning</u>	Rebuilding	Boot boys
	<u>Laminating</u>	Refurbishing	Hand tools
	Label making / Engraving	Constructing:	Beacon lights
	Data entry		Miscellaneous parts
	Large mailings		Buggy whips
Carpentry:	Cable stand construction	Transportation:	Site tours
	Stake sharpening		Other employees from site
Recycling:	Computer / E-waste	Department	Fire extinguishers
	Light bulbs	Assistance:	Painting
	Pop bottle / cans		Monitoring tasks
	Toner cartridges		Sorting / delivery of rainwear
	Metal / Cardboard		

DISABILITY ROADMAP AND THE DUTY TO ACCOMMODATE

Does the employee have a physical or mental disability that interferes with his or her ability to meet a job requirement?¹

YES

NO

Has the employee or the union informed the employer of the disability and need for accommodation? Did the employer know of, or should the employer have known of, the disability and the need for accommodation?²

The question of accommodation does not arise.

YES

NO

The employer has a duty to investigate the availability of accommodation options, involving the union if necessary,³ and considering the individual circumstances of the employee.⁴ Has the employer considered all relevant information needed to accommodate the employee's disability? If the information provided is insufficient for the employer to be able to fulfill this obligation, has it given the employee and the union sufficient opportunity to provide the information?

There is no duty to accommodate, but it may arise later if the employer subsequently becomes aware of the disability.⁵

YES

NO

Do available accommodation options exist?⁶ If so, the employer must make accommodation proposals, unless the job requirement constitutes a *bona fide* occupational requirement (BFOR). To establish a BFOR, the employer must meet all three steps of the test set out in the *Meiorin* case,⁷ as follows.

Failure to thoroughly investigate and consider all relevant information may constitute a breach of the duty to accommodate.⁸

Step 1:

Was the job requirement adopted for a purpose that is rationally connected to the performance of the job?

Step 2:

Was the job requirement adopted in the honest and good faith belief that it was necessary to the fulfillment of that legitimate work-related purpose?

YES

NO

Step 3:

Can the employer accommodate the employee by modifying the existing job requirement without incurring undue hardship? A list of factors to be taken into account when assessing undue hardship is set out in Appendix A.

If steps 1 and 2 are not met, the job requirement will be considered discriminatory. A list of possible remedies is set out in Appendix B.

YES

NO

The job requirement must be modified to accommodate the employee. The failure to do so will be considered discriminatory. A list of possible remedies is set out in Appendix B.

The employer may dismiss the employee without being found liable for discrimination or for breaching its duty to accommodate.

APPENDIX A – FACTORS TO CONSIDER WHEN ASSESSING UNDUE HARDSHIP

Factors considered by arbitrators in assessing undue hardship include the following:

- **Financial cost:** Is it quantifiable? Is it related to the accommodation? Is it substantial? It may constitute undue hardship for an employer to continue to employ a disabled employee if there is insufficient meaningful work available for that employee.
- **Impact on other employees and on the collective agreement (e.g., on seniority rights, job posting provisions, and shift and scheduling entitlements):** Is it substantial? Accommodation proposals that violate collective agreement provisions are usually deemed reasonable only when no other option is available.
- **Interchangeability of the workforce and facilities:** Is it feasible to redistribute functions among employees?
- **Operational requirements of the workplace:** For example, excessive absenteeism, even when innocent, may constitute undue hardship if it threatens the proper functioning of the workplace.
- **Safety:** What is the nature of the risk, its probability, its likely severity, and its impact? Depending on the degree of risk, the employee may or may not volunteer to assume it. The threshold for undue hardship is lower when the safety of the public or other employees is affected.
- **Problems of employee morale:** An employer is not entitled to act on concerns that are themselves offensive to prohibitions against discrimination, e.g., other employees not wishing to work with a person who is disabled.
- **Size of the employer's operations:** The larger the business, the more affordable an accommodation measure is likely to be.

There is conflicting court jurisprudence on the issue of whether a statutory list of factors is exhaustive, or whether other factors may be considered. Under s.15(2) of the *Canadian Human Rights Act*, the factors to be taken into account are listed as "health, safety and cost." The Ontario Human Rights Commission has taken the position that only the factors listed in s.11(2) of the *Ontario Human Rights Code* (cost, outside sources of funding, and health and safety requirements) may be taken into account. Some arbitrators have considered that statutory language has a limiting effect, but other arbitrators do not consider themselves restricted by legislative criteria and take a broader range of factors into account, especially those listed above, based on the seminal cases, *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, 1990 CanLII 76 (SCC), and *Central Okanagan School District No. 23 v. Renaud*, 1992 CanLII 81 (SCC).

APPENDIX B – REMEDIES

Human rights tribunals have wide remedial powers to rectify human rights violations and promote compliance with human rights obligations. Specific powers may vary by jurisdiction, but in general, the following remedies may be granted:

(a) Monetary damages:

- **Pecuniary damages:** For lost wages, benefits, and expenses resulting from discriminatory conduct (for example, the cost of medical reports and treatment/counselling to deal with the effects of discriminatory conduct).
- **Non-pecuniary damages:** For injury to dignity, feelings, and self-respect, including any mental distress and psychological harm arising from the discriminatory conduct, as well as for violation of an employee's inherent right to be free from discrimination and the experience of victimization. Includes compensation for "aggravated" damages, and where expressly permitted by statute, "punitive" or "exemplary" damages.

(b) Non-monetary damages:

- **Individual remedies:** Declarations and compliance orders; reinstatement; order to make available to the person discriminated against the right, opportunity, or privilege that the person was denied as a result of discrimination; order to hire or offer employment; job promotion; accommodation; removal of harasser; letter of reference.
- **Systemic remedies:** Policy change (particularly when a rule is deemed not to be a *bona fide* occupational requirement); training; posting of notices.

While punitive or "exemplary" damages may be awarded in some jurisdictions (see, for example, Manitoba, Yukon, Northwest Territories, and Nunavut), human rights legislation is generally regarded as having a remedial, and not punitive, purpose. Monetary damages are generally awarded on a "make whole" basis, i.e., with the goal of placing the individual discriminated against (as far as this is possible) in the position he or she would have been in but for the violation. With respect to legal costs, the Supreme Court of Canada has ruled that, although the *Canadian Human Rights Act* empowers the Canadian Human Rights Tribunal to award victims of discrimination compensation for "expenses incurred," the Tribunal lacks the authority to award employees compensation for legal costs, as the Act does not specifically mention compensation for "costs," a term of art which refers specifically to legal costs. See *Canada (Canada Human Rights Commission) v. Canada (Attorney General)*, 2011 SCC 53 (CanLII). In some jurisdictions, however, the legislation does expressly allow the awarding of legal costs (e.g., Alberta, Yukon Territory, Nova Scotia, and Prince Edward Island), or allows the awarding of legal costs in specific situations, as where there is "improper conduct" during the course of the human rights proceedings (e.g., British Columbia). In Ontario, individuals may pursue a remedy for human rights violations in the civil courts provided the civil proceedings are initiated and founded on a recognized civil cause of action, and not breach of the statute alone: see s.46.1 of the *Human Rights Code*, R.S.O. 1990, c. H.19.

NOTES

1. The duty to accommodate in the workplace arises when a workplace rule or job requirement discriminates against an employee on the basis of a characteristic that is protected by human rights legislation, such as mental or physical disability. Application of the duty will depend on the circumstances of the case. Where the employer and the union have jointly participated in the formulation of the discriminatory rule, e.g., where the rule is a provision in the collective agreement, the duty falls on both parties to find a reasonable accommodation. Where the employer alone is responsible for the discriminatory rule, the union's duty arises only when its involvement is required to make accommodation possible. In either case, the employer, having charge of the workplace, is expected to initiate the search for reasonable accommodating measures, and the union (once its duty is engaged) is expected to assist in finding or implementing such measures, unless they would result in undue hardship, for example, by unduly interfering with the collective agreement rights of other employees (e.g., seniority rights). Employees, too, have a duty to facilitate the search for, and implementation of, reasonable accommodating measures. In this regard, an employee must co-operate by responding to all reasonable requests for relevant medical and other information, failing which the employer's duty to accommodate may be deemed to have been satisfied.
2. The meaning of "disability" depends on the specific language of applicable human rights legislation, but the term has been broadly interpreted by the courts to include temporary, long-term and permanent conditions, as well as perceived disabilities. Thus, even in the absence of an actual disabling condition, discrimination may be found where it is established that an employer has treated an employee differently based on a perception that he or she has a disability. The duty to accommodate may also arise in so-called "hybrid" situations, i.e., cases involving a mix of (i) voluntary or culpable misconduct, and (ii) involuntary or non-culpable misconduct caused, at least in part, by a disability such as mental illness, or drug or alcohol addiction. This approach requires the arbitrator to apply a disciplinary or just cause analysis to the culpable aspects of the misconduct, and a human rights analysis – including an assessment of the employer's duty to accommodate – to the non-culpable aspects. Difficulties may arise, however, in assessing the extent to which the disability is a causal factor in the (mis)conduct in question, that is, the extent to which it impairs the employee's judgment, or undermines his or her ability to comply with workplace rules: see *Stewart v. Elk Valley Coal Corp.*, 2017 SCC 30 (CanLII). Furthermore, where denial is itself a symptom of a substance use disorder, or a mental health disability, an employee's denial of, or failure to disclose, a disability will not relieve the employer of its duty to accommodate; the employer will in such circumstances have a duty to inquire further into the employee's condition. At the same time, the existence of a disability does not absolve an employee of responsibility in the accommodation process. Thus, some arbitrators have held that, in order to be eligible for accommodation, employees must accept and pursue necessary treatment for their substance use disorder or mental illness. Moreover, while the duty to accommodate may require the employer to tolerate relapse as a "reasonably predictable event" on the road to recovery, arbitrators have generally held that repeated relapses after treatment, with little prospect of future recovery, are an indication that further accommodation would constitute undue hardship.
3. The employee, or the union acting on the employee's behalf, ordinarily has the initial responsibility to inform the employer of his or her disability and need for accommodation. However, where the employer is aware, or reasonably ought to be aware, that the employee has a possible medical or mental health condition affecting his or her job performance and/or conduct in the workplace, the employer has a duty to inquire about the potential need for accommodation before making an adverse decision based on that performance or conduct, and the failure to do so may result in liability for discrimination.
4. Note that a union does not have a general right to notice, information, and consultation whenever an employee requests accommodation from the employer, unless the collective agreement so provides. If it does not, the union's right to participate in the accommodation process is generally limited to the following circumstances: (i) the union would be liable because it has participated in creating a discriminatory policy or rule, as where the collective agreement allows discrimination; (ii) the union's involvement and agreement are necessary to facilitate accommodation, for example, where the proposed accommodation would, without the union's agreement, interfere with the seniority or other collective agreement rights of co-workers; or (iii) an employee requests union involvement. See *Telus Communications Inc. v. Telecommunications Workers' Union*, 2017 BCCA 100 (CanLII), affirming, 2015 BCSC 1570 (CanLII), leave to appeal to S.C.C. dismissed, 2017 CanLII 57754 (SCC).
5. In searching for a suitable accommodation, the employer must conduct an individualized assessment to determine whether incorporating aspects of individual accommodation within the standard or job requirement is possible without undue hardship. See *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, 1999 CanLII 646 (SCC) ("*Grismer*").
6. In exploring accommodation options, the following should be considered: Can the employer modify the job requirements? If not, can the employee perform his or her existing job in a modified or "re-bundled" form, perform another job in its existing form, or perform another job in a modified or re-bundled form? Can the employer tolerate reduced productivity? In this regard, many arbitrators have held that, if an employee cannot be accommodated in his or her current position without causing undue hardship, it is not a breach of the duty to accommodate to transfer an employee with a disability to a lower-rated position. In all cases, an employee is entitled only to reasonable accommodation, not "ideal" or "perfect" accommodation.
7. The duty to accommodate is continuous and dynamic, and a change in circumstances may mean that new accommodation options must be explored. However, where it is clear that, despite the employer's sustained efforts at accommodation, an employee remains unable to fulfill the basic obligations associated with the employment relationship, the employer will have satisfied the test for undue hardship and the duty to accommodate will come to an end. See *Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43 (CanLII).
8. There is an unsettled debate in human rights jurisprudence as to whether there is a stand-alone duty with respect to the procedure of finding a suitable accommodation, the breach of which may independently give rise to a finding of liability and an award of damages, even if it is shown that, in substance, accommodation is not possible without undue hardship. Human rights tribunals and courts in Ontario have recognized the existence of such an independent procedural duty. See *Lee v. Kawartha Pine Ridge District School Board*, 2014 HRTO 1212 (CanLII), and *Lane v. ADGA Group Consultants Inc.*, 2007 HRTO 34 (CanLII), affirmed, 2008 CanLII 39605 (ON SCDC). However, the B.C. Supreme Court and the Federal Court have ruled that, while it may be useful to consider the procedure adopted by the employer in assessing accommodation, a breach of the procedural aspect of the duty to accommodate will not give rise to liability if, ultimately, no accommodation options are in fact available. See *Emergency Health Services Commission v. Cassidy*, 2011 BCSC 1003 (CanLII), and *Canada (Attorney General) v. Cruden*, 2014 FCA 131 (CanLII), affirming, 2013 FC 520 (CanLII).
9. See *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, 1999 CanLII 652 (SCC) ("*Meiorin*").

MENTAL HEALTH RESOURCES – AT A GLANCE

Shepell Employee Family Assistance Program (EFAP)

Immediate and confidential help for any work, health or life concern

- 1-800-387-4765
- www.workhealthlife.com

24-Hour Crisis Line

24/7 phone support and referral service providing confidential and non-judgmental emotional support

- 1-888-353-CARE (1-888-353-2273)
- **You don't need to be in crisis to call**

Canadian Mental Health Association (CMHA)

- www.cmha.ca
- 250-374-0440 (Kamloops)
- 250-832-8477 (Salmon Arm)
- 250-542-3114 (Vernon)
- 250-861-3644 (Kelowna)

Bounce Back ®: For adults and youth

Teaches effective skills to help individuals overcome symptoms of mild to moderate depression or anxiety, and improve their mental health

- Bounce Back today video – www.bouncebackvideo.ca
- Bounce Back Coaching – Talk to Medical practitioner to request referral
- Bounce Back Online - www.bouncebackonline.ca

bc211

Provides information and referral regarding community, government and social services in BC

- www.bc211.ca
- Helplines
 - 2-1-1 (confidential telephone and texting service providing free information and referral)
 - VictimLinkBC 1-800-563-0808
 - BC Gambling Info Line 1-888-795-6111
 - Youth Against Violence Line 1-800-680-4264
 - Alcohol & Drug Information and Referral Service 1-800-663-1441

RCMP

- 250-828-3000 (Kamloops)
- 250-378-4262 (Merritt)
- 250-523-6222 (Logan Lake)
- 250-453-2216 (Ashcroft)

DISABILITY MANAGEMENT COMMITTEE MEMBERS

<u>NAME:</u>	<u>PHONE:</u>	<u>EMAIL:</u>
Bruce Halliburton	250.523.3300	Bruce.Halliburton@teck.com
Brittany Carvath	250.523.3286	Brittany.Carvath@teck.com
Jennifer Rogowski	250.523.3868	Jennifer.Rogowski@teck.com
Heidi Sekhon	250.523.3278	Heidi.Sekhon@teck.com
Candace Droder	250.523.3260	Candace.Droder@teck.com
Kyle Wolff	250.851.1278	president@usw7619.com
Colin Dawes	250.523.3412	Colin.Dawes@teck.com
Duane Mahar	250.523.3310	Duane.Mahar@teck.com
Chad Lindsey	250.523.3533	Chad.Lindsey@teck.com
Jeff Jewell	250.523.3533	Jeff.Jewell@teck.com

MENTAL HEALTH COMMITTEE

NAME	PHONE	EMAIL
Scott Casey	250.320.0721	Scottyjames1967@gmail.com
Kyle Wolff	250.851.1278	president@usw7619.com
Iain Thistlethwaite	250.819.8915	goodtwiniaian@hotmail.com
Mike Fenrich	250.319.7687	Mike.Fenrich@teck.com
Melanie McConnell	250.819.1005	Melanierose1@gmail.com
Cheryl Richards	250.523.3614	Cheryl.Richards@teck.com