



APPLICATION FOR TEMPORARY DISABILITY BENEFITS

PART I - TO BE COMPLETED BY EMPLOYEE

Having been disabled since _____, I hereby apply for temporary disability benefits under the Short-Term Disability provisions of the plan. I understand that the CSI Insurance Plan office or Manulife Financial may contact me to request additional information.

Name _____ Male ___ Female ___ Soc. Ins. No _____
Address _____ Presently employed at _____
Signature _____ Date _____
Phone Number _____

PART II - TO BE COMPLETED BY EMPLOYER

Last Day Worked: _____ Annual salary or wages at date of disability: _____ Job Title: _____

Nature of disability: _____ Expected length of disability: _____

Workers' Compensation Benefits Payable? ___ Yes ___ No If yes, what is the expected monthly benefit? _____

Date _____ Signature _____ Title _____
(Note: Must be completed by the President or Treasurer of the Board or authorized designate)

PART III - TO BE COMPLETED BY TRUSTEES

- 1. Date application received: _____ 2. Date medical evidence of disability received: _____
3. Date of birth: _____ 4. Is this a reoccurrence within 30 days of a prior disability? _____

Payment of Benefits

- 5. Monthly Salary/Wages at date of disability \$ _____
6. Monthly rate of Disability Benefit: 3/4 of (5) or 2/3 of (5) _____
7. Maximum payment for one period of disability: 5 x (6) _____
8. Date benefits begin to accrue (beginning of third week of disability) _____

In the opinion of the Trustees, the Employee satisfies all conditions of the Short-Term Disability provisions of the Plan and is entitled to temporary disability benefits under such provisions. Payment is hereby authorized of the monthly amount shown in Item 6, which shall begin to accrue at the date shown in Item 8. Payments shall cease if and when the aggregate amount paid during one period of disability reaches the amount shown in Item 7.

CALCULATED
By _____
Date _____

BOARD OF TRUSTEES, CSI-CANADA INSURANCE PLAN
By: _____
Date: _____ 20_____