Disability Insurance

PSAC Local Officer's Assistance Kit

Public Service Alliance of Canada
Alliance de la Fonction publique du Canada

Programs Section | Membership Programs Branch | 2010

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Chapter 1

Disability Insurance - A handful of tips for Alliance members

Introduction

Chapter 1 contains the recently revised PSAC publication "Disability Insurance - *A handful of tips for Alliance members*". This publication will be very useful and is an excellent resource for the general membership. Additional copies can be ordered from the PSAC National office.

Website address:

http://www.psac-afpc.org/documents/what/di_ai-e.pdf

Chapter 2

Disability Insurance Plan (Treasury Board) – Employee Information Booklet

Introduction

The following document is an explanatory document produced by the Treasury Board Secretariat to help members understand how the federal disability insurance plan works. There is nothing in the booklet that is incorrect and in some ways it explains the plan well. It should not be confused with the actual Disability Insurance Plan.

We are including it in this kit because it is a reference guide that the employer regularly distributes to disabled workers and because it does provide useful information.

Website address:

http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_865/dwnld/dis-eng.pdf

Chapter 3

Disability Insurance Policy – Sun Life & Treasury Board

Introduction

This is the actual Disability Insurance Policy between Treasury Board and Sun Life of Canada. If you are looking for the exact wording of a provision of the plan this is the document you should access.

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Amendment to Rehabilitation Provision of Disability Insurance Plan

Clic here
Amendment to Rehabilitation Provision of Disability Insurance Plan

or go to the following Internet address

http://www.tbs-sct.gc.ca/hr-rh/in-ai/2006/0726_e.asp?printable=True

See pages 6 to 33 for both:

Amendment to Rehabilitation Provision of Disability Insurance Plan
Treasury Board of Canada Secretariat and Policy 12500-G

Treasury Board of Canada Secretariat   Secrétariat du Conseil du Trésor du Canada

Amendment to Rehabilitation Provision of Disability Insurance Plan

DATE: July 24, 2006

TO: All Public Service Employees

SUBJECT: **Amendment to Rehabilitation Provision of Disability Insurance Plan**

The purpose of this notice is to provide you with information on an amendment to the Rehabilitation Provision of the Disability Insurance (DI) Plan effective January 1, 2006 regarding offsetting from monthly disability benefit earnings. The amendment applies to all DI claimants on an approved Rehabilitation Program on or after January 1, 2006.

Background - Sun Life DI Rehabilitation Program

Currently, under the Rehabilitation Provision of the DI Plan, employees participating in an approved Rehabilitation Program receive a monthly DI benefit in addition to other income (e.g. part-time salary, CPP) up to a maximum defined as 100% of the ***pre-disability salary*** for their occupation or position on the date they began receiving DI benefits. This means that a person on an approved Rehabilitation Program who was earning a salary of $45,000 when their DI benefits began would continue to have a ceiling of $45,000 even if the salary for their pre-disability position increased during the period of the Rehabilitation Program.

Amendment to the Rehabilitation Provision of the DI Plan

Effective January 1, 2006, there was a change to the maximum income level that an employee on an approved Rehabilitation Program may earn. An employee may now earn their DI benefit plus any other income ((e.g. part-time salary, CPP) up to a maximum defined as 100% of the ***current*** annual rate of remuneration for the pre-disability occupation or position.

Implementation Process:

Departments have been notified of this change and will be reporting salary revisions since January 1, 2006 to Sun Life for DI claimants on an approved Rehabilitation Program on or after that date.

There is no need to contact your Compensation Advisor to initiate a review of your file. If you were on an approved Rehabilitation Program on or after January 1, 2006, your Compensation Advisor will review your file automatically to determine if the salary for your pre-disability position has increased since you began receiving DI benefits. Your Compensation Advisor will notify Sun Life directly regarding updated salary data.

Based on updated salary data, your DI benefit may be adjusted, depending on the level of your other income. You will be advised by Sun Life if your benefits are adjusted.

If you were on an approved rehabilitation program prior to January 1, 2006 and you feel you were adversely affected by the former rehabilitation provision, you may contact the Treasury Board Secretariat for a review of your file. For additional details you may contact the Treasury Board Secretariat at:

E-mail: lrco-rtor@tbs-sct.gc.ca
Fax : (613) 952-9421
Phone : 1-866-892-2295

Mailing Address :
Labour Relations Compensation Operations
Treasury Board of Canada Secretariat
400 Cooper Street
Ottawa, Ontario K1A 0R5
Attention: DI Rehabilitation Provision

The Treasury Board Secretariat will accept such requests for a period of one year from the date of this notice.

Phil Charko

Assistant Secretary
Pensions and Benefits Sector

Date Modified: 2006-07-26

HEAD OFFICE
TORONTO, CANADA

POLICYHOLDER HER MAJESTY THE QUEEN IN RIGHT OF CANADA REPRESENTED BY THE PRESIDENT OF THE TREASURY BOARD

POLICY NUMBER 12500-G.

EFFECTIVE DATE April 30, 1997

POLICY ANNIVERSARIES January 1st, 1998 and the same day of each subsequent year.

PREMIUM DUE DATES The Effective Date and thereafter the 1st day of each month.

CURRENCY Canadian Dollars, lawful money of Canada.

PLACE OF PAYMENT Benefits and premiums are payable at any office in Canada of Sun Life Assurance Company of Canada.

PLACE OF ISSUE Province of Ontario.

The group policy previously written under the same policy number is cancelled and replaced by this group insurance policy on the Effective Date.

The provisions of this group insurance policy apply to an Employee who was insured under the previous policy on the date immediately before the Effective Date, except that the provisions of the previous policy relating to the amount and type of benefits will apply to any such insured Employee who was then Totally Disabled and entitled to benefits.

GROUP
DISABILITY INSURANCE PLAN

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4. Definitions

Actively At Work

An Employee is actively at work on any day during which he/she performs all of the usual and customary duties of his/her occupation on behalf of the Employer or a Participating Employer for the scheduled number of hours of the day.
An Employee is deemed Actively At Work on a scheduled non-working day if he/she was Actively At Work on his/her last scheduled working day.

Commensurate Occupation

An occupation for which the current salary or current rate of pay is not less than 66 2/3% of the then current salary for the Employee's own regular occupation.

Doctor

A physician or surgeon licensed to practice medicine, other than a person who practices dentistry, veterinary medicine, osteopathy, chiropractics, podiatry, naturopathy or drugless healing.
A Doctor who is also an Employee is not considered a Doctor in connection with his/her own medical condition.

Employee

A person working on a Full-Time or Part-Time basis, who holds an office or position in (i) the Public Service as listed in Part I of Schedule I of the Public Service Staff Relations Act, or (ii) with a Participating Employer, and who:

1. is employed in a continuing position during pleasure or for a term of more than 6 month's duration, or
2. has been continuously employed for a period of at least 6 months, or
3. is a Seasonal Employee who has completed the required Qualifying Period or been reinstated under the Commencement Of Insurance section.

Employee includes, where the context of the policy requires, a former Employee who is eligible for benefits under this policy.
Employee **excludes** anyone:

1. who has attained the age of 64 years and 9 months,
2. who is engaged outside of Canada to work at a usual place of Employment outside Canada, or
3. to whom the Public Service Management Insurance Directives apply, other than a represented Employee who has relinquished all group life and health benefits available to the Employee under the Public Service Management Insurance Directives.

Sun Life Assurance Policy number 12500-G.

Definitions

Sun Life Assurance Policy number 12500-G.

Definitions

Employer

The Policyholder.

Employment

Employment as an Employee or a Seasonal Employee by the Employer or a Participating Employer.

Full-Time

Assigned hours of work equal to the normally scheduled daily, weekly, or monthly hours of work established for a Full-Time Employee in the relevant occupational group.

Hospital

An institution which charges its patients for room and board, provided such charges qualify, in whole or in part, for payment under a plan toward which contributions are made by the Government of Canada pursuant to the Canada Health Act, or under the Public Service Health Care Plan and includes a tuberculosis or mental hospital recognized as such by the appropriate provincial or other government authority.

Illness

Bodily injury, disease, mental infirmity, or sickness.

Inception Date

For Full-Time Employees:

November 1, 1970 for the Employer and for those Participating Employers who were given prior Treasury Board approval for inclusion under the Plan effective that date.
For any other Participating Employer, the effective date declared in the Treasury Board authorization of its inclusion under the Plan.
For Part-Time Employees:

September 1, 1982 for the Employer and for those Participating Employers who were given prior Treasury Board approval for inclusion under the Plan effective that date.
For any other Participating Employer, the effective date declared in the Treasury Board authorization of its inclusion under the Plan.

Insured Earnings

For Full-Time Employees:

The Employee's current annual salary, at the relevant date, as defined in Part II of the Public Service Superannuation Act, adjusted to the next higher multiple of $250, if not already such a multiple.

For Part-Time Employees:

The annual salary of a Full-Time Employee in the same occupational group and level, at the relevant date, multiplied by the fraction obtained when the Employee's assigned hours of work are divided by the normally scheduled Full-Time hours of work for the Employee's occupational group, adjusted to the next higher multiple of $250, if not already such a multiple.
For all Employees:

For the purposes of this policy, changes in an Employee's Insured Earnings will take effect on:

1. the effective date of an increase, if authorized before such effective date
2. the first day of the month following the effective date of a decrease, if authorized before such effective date.
3. the first day of the month following the month in which an increase or a decrease was authorized, if such increase or decrease was authorized retroactively.

Participating Employer

Any organization or agency:

1. which forms part of the Public Service as defined in the Public Service Superannuation Act, or
2. which has Employees who are subject to that Act,

where such organization has requested, and the Treasury Board approved, its inclusion under the Plan.

Part-Time

Assigned hours of work which exceed one-third of the normally scheduled daily, weekly, or monthly hours of work established for a Full-Time Employee in the same occupational group.

Plan

The Group Disability Insurance Plan for Employees, as represented by this policy.

Sun Life Assurance Policy number 12500-G.

Definitions

Qualifying Period

For Seasonal Employees, a continuous period of 6 months of Employment that took place:

1. during the person's working seasons, or
2. during Employment other than as a Seasonal Employee, or
3. partly during the person's working season and partly during Employment otherwise than as a Seasonal Employee.

For the purposes of this definition, a period of Employment is deemed to be continuous if, during two consecutive working seasons, the interruption does not exceed a period of 6 weeks.

Reasonable And Customary Treatment Program

A course of medical care, which is:

1. performed or prescribed by a Doctor,
2. of the nature and frequency usually required for the condition involved, and
3. required in the opinion of Sun Life.

Seasonal Employee

A person who:

1. is appointed as a Seasonal Employee, as defined in the Public Service Terms and Conditions of Employment Regulations, or
2. is appointed to perform duties for a period of less than 12 months in each successive year of Employment,

but does not include a person who is appointed as a teacher at a school established under

1. the Indian Act, or
2. an ordinance of the Northwest Territories.

Total Disability

The condition of being Totally Disabled.

Sun Life Assurance Policy number 12500-G.

Definitions

Totally Disabled

An Employee is Totally Disabled if he/she is in a continuous state of incapacity due to Illness which

1. while it continues during the Elimination Period and the following 24 months, prevents the Employee from performing each and every duty of his/her regular occupation or Employment.

Loss or suspension of a license, due to Illness unrelated to alcoholism or drug addiction, which such Employee requires to carry out his/her regular occupation, will be considered Total Disability during the Elimination Period and the following 24 months, but only while such license continues to be withheld for the same reason.

2. while it continues thereafter, prevents the Employee from engaging in any Commensurate Occupation for which he/she is or becomes reasonably qualified by education, training or experience.

In no event, however, will an Employee be considered Totally Disabled if during any period he/she does not take part or co-operate in a Reasonable And Customary Treatment Program.

5. Commencement Of Insurance

Employees Employed Before Inception Date

Insurance for an Employee who was employed before the Inception Date applicable to his/her Employer or Participating Employer commences, unless the Employee is on a leave of absence, on whichever of the following dates is applicable.

1. the Inception Date of his/her Employer or Participating Employer, if the Employee's written request for insurance is received by his/her personnel office on or before that date,

2. the first day of the month coincident with or next following the date the Employee's written request for insurance is received by such personnel office, if it is received within two months after such Inception Date, or

3. the first day of the month coincident with or next following the date the Employee's written request for insurance is received by his/her personnel office, provided evidence of the Employee's insurability at the date of such request has been (or is subsequently) approved by Sun Life, if such written request for insurance is received later than two months after such Inception Date.

If an Employee's written request for insurance is received by his/her personnel office during a leave of absence, such Employee's insurance will commence on the first day of the month coincident with or next following the date the Employee is again Actively At Work, provided evidence of insurability, if necessary, at such date has been (or is subsequently) approved by Sun Life.

Employees Employed On Or After Inception Date

Insurance for an Employee employed on or after the Inception Date applicable to his/her Employer or Participating Employer commences

1. if the Employee is not a Seasonal Employee:
   A. on the date on which a person appointed for a term of six months or less completes six months of continuous Employment, or
   B. for any other person on the day on which that person becomes an Employee
2. if a Seasonal Employee, on the day such person becomes an Employee.

Reinstatement Of Insurance

For other than Seasonal Employees:

An Employee who ceases to be insured because of Termination Of Employment and who becomes employed by the Employer or a Participating Employer on a continuous Full-Time or

Part-Time basis for a term of six months or less within three months after such termination, will become insured on the date Employment recommences.

For Seasonal Employees:

Any Seasonal Employee whose insurance has been terminated under this policy due to the cessation of his/her working season, will become insured on the day the Seasonal Employee is again Actively At Work during his/her next working season.

Actively At Work Requirement

In any event, if any Employee is not Actively At Work on the date his/her insurance would otherwise commence, such insurance commences only when the Employee is Actively At Work.

6. Terminations

Individual Terminations

All Employee insurance ends on the earliest of:

1. the date of Termination Of Employment,
2. the date of termination of this policy,
3. the date of termination of a Seasonal Employee's working season,
4. the date an Employee, who is not Totally Disabled, attains age 64 years and 9 months, and
5. the date the Employee commences unpaid Surplus Status.

Termination Of Employment

Termination Of Employment occurs on the earlier of the date a person ceases to qualify as an Employee and the date he/she ceases to be Actively At Work.
However, Employment is deemed to continue:

1. for any period the Employee is absent from work on any paid leave,
2. for any period the Employee is granted leave without pay for any reason,
3. for any period the Employee is suspended from duty or pending an appeal under a grievance procedure, or
4. for any period the Employee is participating in a legal strike.

Termination Of Policy

The policy terminates at the end of the grace period allowed for premium payments if its premium remains unpaid.
If the Policyholder gives Sun Life written notice that this policy is to be terminated, it terminates on the later of:

1. the date specified in the notice, and
2. the date Sun Life receives the notice.

By giving 180 days prior written notice, Sun Life may terminate the policy on:

1. any Policy Anniversary, or
2. any Premium Due Date, if less than 100% of the eligible Employees are insured.

7. Premiums

Premium Calculation

The premium due is the sum of the monthly premiums for all insured Employees at the Premium Due Date based on monthly rates recommended by Sun Life and established by the Policyholder following agreement between the Policyholder and Sun Life.
Sun Life may from time to time recommend to the Policyholder a change in the premium rate for any policy year to reflect recent experience under this policy.

Premium Payments

Each premium is to be paid on or before its Premium Due Date by the Policyholder.
A grace period of 60 days is allowed to pay each premium. Premiums are payable while this policy remains in force.

Sun Life is not required to ascertain:

1. that any amounts referred to as contributions by Employees are, in fact, contributed by Employees, or
2. that all or any amounts contributed by Employees are applied to the payment of premiums.

Premium Adjustments

If a change in policy terms is effective on a date other than a Premium Due Date, a proportionate premium charge or refund will be made where applicable from the date of such change.
Other premium charges for insurance which increases or commences on a date other than a Premium Due Date are made effective from the Premium Due Date following the date of such increase or commencement.
Other premium refunds for insurance which decreases or terminates on a date other than a Premium Due Date are made effective from the premium Due Date following the date of such decrease or termination.

8. Claims

Notice And Proof Of Claim

Sun Life must be given,

1. written notice of claim by mail or delivery to any office in Canada of Sun Life by the earliest of the following dates:
   A. 6 months from the commencement of Total Disability,
   B. 30 days before the end of the Elimination Period, and
   C. within 30 days from the termination of this benefit provision;
2. written proof of claim, at the Employee's expense, 90 days after the end of the Elimination Period; and
3. such continuing written proof of claim, at the Employee's expense, including, but not limited to, attending Doctor's statements, questionnaires, reports and copies of clinical notes and test results from the Employee's Doctors as Sun Life may require from time to time,

failing which no benefits or further benefits will be payable to the Employee in respect of such Total Disability.

Failure to provide such notice or proof of claim will not invalidate or reduce a claim if it was not reasonably possible to provide the notice or proof within the required time periods and the notice and proof are given as soon as reasonably possible. Every reasonable effort should be made to submit the notice and proof of claim within one year of the required time periods.

Payment Of Benefits

Benefits payable during the lifetime of the Employee are payable to the Employee.

Benefits remaining unpaid or becoming payable after the Employee's death are payable to the Employee's estate. Employees, or an Employee's personal representative, to whom benefits have been paid must provide Sun Life with a valid discharge.

If the Employee does not have the capacity to give a valid discharge for benefit payments, then payment up to $10,000 may be made to:

1. a relative by blood or connection by marriage of the Employee,
2. any person appearing to Sun Life to be equitably entitled to such benefits by reason of having incurred expenses for the maintenance, medical attendance or burial of the Employee, or to have a claim against the estate of the Employee in relation thereto,

and such payment discharges Sun Life to the extent of the amount paid.

Examinations And Assessments

Sun Life may require, at its own expense, an Employee to undergo such medical, psychological, rehabilitational and vocational examinations and assessments, from time to time, as are arranged by Sun Life, failing which payment of benefits or further benefits will be suspended.

The Employee's obligation and Sun Life's right in this regard shall continue as long as the Employee claims benefits or further benefits regardless of whether such benefits have been paid and regardless of the commencement of litigation or arbitration.

Proof Of Age

Sun Life may request proof of age of an Employee. Benefits payable may be suspended until the requested proof is given.
If the age of an Employee has been misstated, benefits and premiums will be adjusted based on the true age.

Subrogation

In order to determine whether the cause or circumstances giving rise or contributing to any claim under this policy would also give rise to a cause of action against a person, partnership, corporation or other entity (the "Third Party"), Sun Life may require any Employee to provide a written statement as to the cause or circumstances giving rise or contributing to any such claim. Sun Life may suspend payment of benefits or further benefits to an Employee who refuses to provide such a statement.

Where benefits under this policy have been paid or may be payable to an Employee and the Employee has a right of action against a Third Party for recovery of loss of income which otherwise would have been earned by the Employee during the whole or any part of the period that benefits are paid, or may be payable, to the Employee under this policy,

1. any amount recovered by the Employee from the Third Party (including general damages, damages for loss of income, interest and legal costs, whether recovered through settlement or trial), less the Employee's legal costs expended for such recovery, shall be deemed to be the Employee's Net Recovery from the Third Party;
2. the Employee shall pay to Sun Life an amount equal to 75% of his/her Net Recovery from the Third Party (to a maximum of the amounts paid to the Employee under this policy), such percentage of his/her Net Recovery to be held in trust by the Employee for Sun Life until payment is made to Sun Life;
3. in the event that any benefits not paid to the Employee under this policy are subsequently determined to have been payable, Sun Life shall be entitled to set off against its liability for such benefits the amount the Employee would have been obliged to pay pursuant to subparagraph 2. hereof if such benefits had been paid to the Employee before the Employee obtained his/her recovery from the Third Party; and
4. the Employee shall provide Sun Life, free of charge:
   A. prompt notice of the commencement of any legal proceedings against a Third Party;

B. such reports as Sun Life may reasonably require from time to time concerning the status of legal proceedings and/or settlement negotiations with the Third Party;

C. copies of such documents in the Employee's possession or control that relate to his/her right of action against the Third Party as Sun Life may reasonably require from time to time; and

D. prompt notice of the conclusion of any settlement or judicial disposition of his/her right of action against the Third Party.

Sun Life may require the Employee to sign an acknowledgment that he/she is bound by this provision. Sun Life may withhold or discontinue benefits upon any refusal by the Employee to honour any terms of this provision.

9. Long Term Disability Insurance Benefit Provision

Amount Of Monthly Benefit

Subject to the sub-section entitled Rehabilitation, the Monthly Benefit shall be:

1. 70% of Insured Earnings, as at the date of completion of the Elimination Period, divided by 12, less
2. all Other Income earned in or attributable to a particular month.

If an Employee's Total Disability is deemed by the Department of National Revenue to be due to a condition which commenced prior to January 1, 1974, then such Employee's Monthly Benefit will be 60% of Insured Earnings, as at the completion of the Elimination Period, divided by 12 and the result reduced by 85% of any Other Income, which is subject to income tax and by 100% of any Other Income, which is not subject to income tax. However, if the benefits payable under this provision are deemed to form part of the Employee's gross income for the purposes of the Income Tax Act, then such Employee's Monthly Benefit will be calculated as described in the first sentence of this sub section.

Other Income

Other Income means:

1. Compensation or profit, except as otherwise provided in the sub-section entitled Rehabilitation, from any occupation or business enterprise in which the Employee is actively engaged while Monthly Benefits are payable.
2. Any indemnity for loss of income provided for the same or a subsequent disability (except in case of a representative for an Employee Bargaining Agent, as provided below) under any other group insurance plan or under any policy issued to the Employee as a result of his/her membership in an association of any kind.
3. Any amount of income provided for the Employee for the same or subsequent disability under a contract of motor vehicle insurance which provides mandatory disability income benefits.
4. Any amount of income provided for the Employee by reason of the same or a subsequent disability under the legislation of any government or emanation thereof, including but not limited to the Canada or Quében Pension Plan, but excluding:
   A. any amount of war disability benefit provided under the Pension Act to the extent of
      a) the amount payable to the Employee on the date he/she completed the Elimination Period, plus any subsequent increase in such amount arising under the Pension Act, because of an adjustment related to the Consumer Price Index for Canada, plus
      b) any increase provided by subsequent amendments to the Pension Act,
   B. the amount of any increases paid under the Canada or Quében Pension Plan arising as a result of the escalation provisions of those plans related to changes to the Consumer Price Index for Canada, and

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

C. any amounts received pursuant to statutory Employment Insurance programs which the Employee is obliged to repay upon receipt of benefits from Sun Life.

5. Any amount of income provided for the Employee by reason of the same or a subsequent disability under the Government Employees Compensation Act or under any provincial Workers' Compensation Act.
6. Any amount of income provided for the Employee by means of an immediate annuity, annual allowance or deferred annuity payable in respect of the Employee's own service under the Public Service Superannuation Act or under the Special Retirement Arrangements Act, including any elective service, but excluding the amount of any increases in such income paid as a result of the escalation provisions of those Acts related to changes in the Consumer Price Index for Canada.

This amount will be deducted in the following manner:

Circumstances of Termination	**Public Service Superannuation Act (PSSA) pension benefit**	**Deduction from the Disability Insurance Plan Monthly Benefit**
I. For an Employee whose employment is terminated and who has less than 2 years of service.	1) Return of Contributions	1) This lump sum pension benefit is not deducted.
II. For an Employee whose application for disability retirement under the PSSA is approved.	1) Immediate Annuity or 2) Lump Sum Payment	1) The full monthly amount is immediately deducted. 2) A monthly amount equivalent to the immediate annuity is immediately deducted until the total amount of the Lump Sum has been deducted.
III. For an Employee whose application for disability retirement under the PSSA is not approved.	1) Deferred Annuity at age 60 or 2) Annual Allowance from age 50 onwards or 3) Actuarial Transfer Value or 4) Return of Contributions	1) The monthly amount is deducted when the Employee reaches age 60. 2) The monthly amount is deducted when it becomes payable. 3) & 4) A monthly amount equivalent to the Deferred Annuity is deducted when the Employee reaches age 60 and until the total of the Actuarial Transfer Value or the Return of Contributions

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

		has been deducted.

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

IV. For an Employee who does not apply for a disability retirement under the PSSA.	1) Immediate Annuity on Account of Age or 2) Deferred Annuity at age 60 or 3) Annual Allowance from age 50 onwards or 4) Actuarial Transfer Value or 5) Return of Contributions	1) The full monthly amount is immediately deducted. 2), 3), 4) & 5) A monthly amount equivalent to the immediate annuity is immediately deducted and until the total of the Actuarial Transfer Value or the Return of Contributions has been deducted. If the Employee proves his application for disability retirement under the PSSA has been declined, the amount is deducted as in III above.

Estimates Of Other Income

Sun Life reserves the right to reduce the Monthly Benefit of an Employee according to its estimate of the amount to which the Employee would be entitled:

1. if the Employee's application for retirement on the grounds of disability under the Public Service Superannuation Act, were made and approved;
2. if the Employee's application for benefits under the Government Employees Compensation Act or under any provincial Workers' Compensation Act, were made and approved;
3. if the Employee's application for benefits under the Canada or Québec Pension Plan were made and approved.

However, any such reduction will cease and the amount of reduction already made will be reimbursed, if proof is submitted to Sun Life that after final determination (including all levels of appeal), the Employee's application for such income has been disallowed. If the Employee's application for such income is approved for an amount other than that previously estimated by Sun Life, the Employee's Monthly Benefit will be retroactively adjusted to the Monthly Benefit payable on the basis of the amount approved.
An Employee may also defer such reduction in respect of his/her Canada or Québec Pension Plan benefits if the Employee agrees in writing (by signing a form provided for this purpose by Sun Life),
1. to make application for benefits under the Canada or Québec Pension Plan,
2. to reimburse Sun Life any benefits under this policy which would otherwise have been reduced, should the claim for Canada or Québec Pension Plan benefits be approved, and

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

3. to execute a direction authorizing Canada or Québec Pension Plan (as available) to pay to Sun Life the amount of all benefits accrued from the time of application to the time of approval.

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In the event that one or more lump sum payments are made in lieu of instalments of other periodic income, the amount of the Employee's Monthly Benefit will be calculated on the basis of the instalments which would otherwise have been paid.

Representative For An Employee Bargaining Agent

Where an Employee is granted leave of absence to act as a representative for an Employee Bargaining Agent and where the Bargaining Agent has a group disability plan covering the additional remuneration by the Agent to the Employee, any benefits arising from such additional remuneration under such group disability plan will not be deducted from benefits under this policy.

Changes In Monthly Benefit

Subject to the Indexation sub-section below, an Employee's Monthly Benefit will not be increased after the date of completion of the Elimination Period, unless the increase is due to an increase in the Insured Earnings authorized retroactive to a date which is before the completion of the Elimination Period.

Payment Of Monthly Benefit

Upon receipt of Notice and Proof of Claim that:

1. an Employee became Totally Disabled while insured and is under a Reasonable and Customary Treatment Program, and
2. Total Disability continued beyond the Elimination period,

the Monthly Benefit will be paid while the Employee continues to be Totally Disabled, subject to the terms and provisions of this policy.
One-thirtieth of the Monthly Benefit is payable for each day Total Disability continues for a period less than a full month.
Benefits are payable monthly in arrears, commencing on the completion of (but not payable in respect of) the Elimination period.

Indexation

While benefits are payable, the Monthly Benefit will be increased on January 1st of each year to reflect any increase which is provided by the escalation provisions of the Public Service Superannuation Act. In no event, will any increase exceed 3%.

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Elimination period

For an Employee other than a seasonal Employee:

The Elimination Period begins with the first full day of Total Disability and ends on the later of the days on which:

1. the Employee has completed
   A. periods of Total Disability due to the same cause, which when accumulated within a period of 12 consecutive months, prevent the Employee from being Actively At Work for 13 weeks, or
   B. an uninterrupted period of Total Disability of 13 weeks, and
2. the Employee's accumulated sick leave credits and other paid leave granted (other than vacation leave) are completely exhausted.

For a Seasonal Employee:

The Elimination Period begins with the first full day of Total Disability and ends on the latest of the days on which:

1. the Seasonal Employee has completed
   A. periods of Total Disability due to the same cause, which when accumulated within a period of 12 consecutive months, prevent the Employee from being Actively At Work for 13 weeks, or
   B. an uninterrupted period of Total Disability of 13 weeks, and
2. the date on which the Seasonal Employee's accumulated sick leave credits and other paid leave granted (other than vacation leave) are completely exhausted, and
3. the date on which earnings deferred from the Seasonal Employee's working season cease, as may be decided by the Employer or Participating Employer in accordance with rules which apply equally to all Seasonal Employees within the same classification.

Maximum Benefit Period

Payment is made until the earlier of:

1. the Employee's 65th birthday, and
2. the date the Employee is no longer Totally Disabled, or in case of death, the last day of the month coincident with or next following the date the Employee dies.

Successive Periods Of Total Disability

While the policy is in force, an Elimination Period will not be applied if an Employee, in the interval between successive periods of Total Disability, is Actively At Work for a period of less than:

1. 1 month, if the subsequent Total Disability is due to an entirely unrelated cause or Illness, or
2. 6 consecutive months, if the subsequent Total Disability is due to another Illness resulting from the same cause, or
3. 12 consecutive months, if the subsequent Total Disability is due to the same Illness.

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Newly acquired sick leave credits must be exhausted before an Employee, to whom this sub-section applies, becomes eligible for benefits.

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Where this sub-section applies:

1. the Monthly Benefit, except as provided below, is the same as that paid for the final month of the initial period of Total Disability, and
2. the initial Elimination period and the period for which benefits were paid under the prior claim shall be considered to form part of the Employee's new claim for the purpose of determining whether the Employee is Totally Disabled and for the purpose of determining the application of sub-paragraph 2 of the sub-section entitled Mitigation of this benefit provision.

If during the interval between the successive periods of Total Disability:

1. the Employee is Actively At Work for a period of at least 13 weeks, and
2. premium payments for the Employee's insurance reflect an increase in the Employee's Insured Earnings,

then the Monthly Benefit will be increased to reflect such higher Insured Earnings, when the sum of the existing Monthly Benefit paid during the period equal to the Elimination Period, which has been waived, is exceeded by the accumulated value of the increase in the Monthly Benefit resulting from the higher Insured Earnings.

Waiver Of Premium

Premiums for this benefit are waived, (a) for an Employee, while he/she is in receipt of a Monthly Benefit, or (b) for an Employee who was on sick leave without pay during an Elimination Period, which was subsequently completed.

Benefit after policy termination

If this policy terminates after an Employee becomes Totally Disabled, then, during the uninterrupted continuance of such Total Disability, the Employee is entitled to the benefit provided as though this provision had not terminated, subject to all other terms and conditions of this policy.

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Limitations

Payment is not made for

1. a Total Disability due to or resulting directly or indirectly from an Illness which existed on or before the commencement date of the Employee's insurance unless
   A. the Employee has been insured under this provision for a continuous period of not less than 13 weeks during which he/she:
      a) has not received medical care, treatment, prescription medicines or diagnostic procedures for such Illness from a Doctor or from appropriately qualified personnel acting under the direction of a Doctor, and

b) has been continuously Actively At Work (for the purposes of this clause, Sun Life will disregard absences of a total of not more than 2 days during the same 13 week period), or

B. the Total Disability commenced after the Employee has been insured under this policy for a period of at least 12 months.

For an Employee who has been laid off and is reappointed under the Work Force Adjustment Directive (WFAD) or a similar policy of a Participating Employer within one year of the date of the lay-off, this Limitation will not apply to Total Disability which commences after such Employee has been insured under this policy for a period of 12 months, including any insured period before the lay-off.

Any period of time that a represented Employee, who relinquished all group life and health insurance benefits available to him/her under the Public Service Management Insurance Directives, was insured continuously under the group long term disability policy provided under such Directives prior to commencing coverage under this policy shall be counted in determining both the 13 week and 12 month periods referred to above.

If an Employee, whose insurance terminated because of Termination Of Employment, becomes insured again under this policy, in accordance with the terms of the Commencement Of Insurance Section, then such Employee is subject to this Limitation as if his/her insurance commenced for the first time on the most recent commencement date.

2. a Total Disability due to abuse of drugs or alcohol unless.
   A. the Employee is participating to the satisfaction of Sun Life, in a Reasonable And Customary Treatment Program or in a treatment program for drug or alcohol abuse recommended or approved by Sun Life, and such participation began not later than 13 weeks from the commencement of the period of Total Disability, or
   B. there is also an organic disease present which would cause Total Disability even if the use of drugs or alcohol ceased.

Exclusions

A benefit is not paid for a Total Disability which is due to or results from

1. participation in any riot, civil commotion or insurrection.
2. intentionally self-inflicted injuries or attempted suicide (while sane or insane).
3. commission or attempted commission of a criminal offence by the Employee.
4. the hostile action of any armed forces.

Exclusion No. 4 will be waived for an Employee, other than one on active duty (including for training purposes) in the armed forces of any country, while on an assignment outside Canada, or while on a travel status, as determined by the Employer or a Participating Employer. Any benefit which may become payable because of a Total Disability due to an incident, which occurred outside Canada, will be subject to such Employee's entitlement to receive compensation under the Government Employees Compensation Act, R.S.C. 1985, Chapter G-5.

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

Rehabilitation

Rehabilitative Program

A Rehabilitative Program is a program:

1. of part-time or full-time work for compensation or profit while an Employee is unable, because of Illness, to be Actively At Work at his/her own regular occupation, or
2. of non-remunerative vocational training or work for the purpose of enabling the Employee to return to his/her own regular occupation or to become reasonably qualified for a Commensurate Occupation; and

is approved in writing by Sun Life, in advance, as a Rehabilitative Program.

Effect On Calculation Of Benefits

Any compensation or profit from a Rehabilitative Program shall be deemed not to constitute Other Income. However, the Monthly Benefit for an Employee participating in a Rehabilitative Program shall be subject to reduction so that the total of the Employee's Monthly Benefit, compensation or profit from his/her Rehabilitative Program and any Other Income for any particular month does not exceed 100% of the Employee's monthly Insured Earnings as at the date he/she completed the Elimination Period.
An Employee's participation in a Rehabilitative Program shall be deemed to have concluded upon the earliest of:

1. the first 24 months following the Employee's completion of the Elimination Period,
2. the end of the Maximum Benefit Period, and
3. notice in writing from Sun Life that it no longer approves of the program as a Rehabilitation Program.

Residual Benefit

If an Employee engages in any occupation for compensation or profit after participating in a Rehabilitative Program, and while the Employee remains Totally Disabled, then, for the 18 months following the conclusion of the Employee's participation in a Rehabilitative Program, or the end of the Maximum Benefit Period, whichever is earlier, he/she shall receive a monthly payment (in lieu of and not in addition to the Monthly Benefit) equal to 30% of his/her Insured Earnings, as at the date such Employee completed the Elimination Period ("Residual Benefit"). However the Employee's monthly Residual Benefit shall be subject to reduction so that the total of the Employee's monthly Residual Benefit, compensation from such occupation and any Other Income for any particular month does not exceed 100% of his/her monthly Insured Earnings as at the date he/she completed the Elimination Period.

Sun Life Assurance Policy number 12500-G.
- Long Term Disability Insurance Benefit Provision

Expenses Associated With Rehabilitative Programs

Where Sun Life expressly agrees in writing, in advance, it will pay an Employee's expenses associated with a Rehabilitative Program, other than expenses normally associated with employment. Sun Life's obligation hereunder shall at all times be limited to a maximum of three times the Employee's Monthly Benefit applicable at the commencement of the Rehabilitative Program. Such expenses shall not be paid for any period after notice in writing that Sun Life's approval of the program as a Rehabilitative Program, or for the payment of such expenses, has been withdrawn. Such expenses also shall be subject to payment in accordance with the subsection entitled Subrogation in this policy.

Effect On Elimination Period

The commencement of a Rehabilitative Program during the course of an Employee's Elimination Period shall be deemed not to interrupt the running of the Elimination Period.

Mitigation

During any period of Total Disability, an Employee shall make reasonable efforts:

1. to facilitate his/her recovery, including participation in any Reasonable And Customary Treatment Program or Rehabilitative Program or acceptance of any reasonable offer of modified duties by the Employer or any Participating Employer;
2. to retrain to qualify for a Commensurate Occupation, upon it becoming reasonably apparent that the Employee will not be able to return to his/her regular occupation within the first 24 months that benefits are paid, or may be payable, under this policy;
3. to return to his/her regular occupation during the first 24 months that benefits are paid, or may be payable, under this policy, or to obtain work in a Commensurate Occupation after the conclusion of the first 24 months that benefits are paid, or may be payable; and
4. to obtain Other Income.

In the event of breach of this provision, Sun Life may withhold or discontinue benefits.

Assignments

The benefits payable under this policy are not assignable and may not be given as security.

10. General Provisions

Gender

The use of "he", "his" and "him" refers to both the masculine and feminine genders.

Definitions

Certain capitalized words are defined throughout the text or under the Definitions section of this policy.

Insurance Data

The Policyholder is to provide Sun Life with information required for the calculation of premiums and to ensure that policy terms are fulfilled. Sun Life may inspect pertinent records of the Employer or any Participating Employer.

Clerical Or Mechanical Errors

If a clerical or mechanical error by the Employer or Participating Employer or by Sun Life results in a person being incorrectly classified under the policy, then such person will be classified according to the true facts.

Modifications

The terms and/or benefits of this policy may be changed if mutually agreed to by the Policyholder and Sun Life. Any such change will be identified by a line in the right margin, pending subsequent reissue of the policy as amended and consolidated.

Receiving and Releasing Necessary Information

Sun Life will comply with all relevant federal and provincial legislation protecting personal information. Any person claiming benefits under this contract must give Sun Life all necessary information and authorization needed for underwriting, administration and paying claims.

Chapter 4

Disability Insurance Application Forms

Introduction

Instructions on how to fill out the forms are included in the claim document by Sun Life.

Once the potential claimant or her/his health professional realizes that a health problem may prevent them from performing the regular duties of their occupation they should complete this claim and distribute it according to the instructions that accompany it. The instructions say that the enclosed form must be completed in full within 90 days of the claimant becoming disabled.

Claim for Disability Insurance Employee's Statement Policy No. 12500-G
http://www.tbs-sct.gc.ca/tbsf-fsct/330-302-eng.pdf

Claim for Disability Insurance Employer's Statement Policy No. 12500-G
http://www.tbs-sct.gc.ca/tbsf-fsct/330-303-eng.pdf

Claim for Disability Insurance Employee's Medical Information and Attending Physician's Statement Policy No. 12500-G
http://www.tbs-sct.gc.ca/tbsf-fsct/330-304-eng.pdf

Chapter 5

A Step-by-step Guide to the Disability Claim Process

Introduction

Chapter 5 contains a copy of the pamphlet "A Step-by-Step Guide to the Disability Claim Process."

We include it because it may be the only written information that members have. They may refer to it when they ask you for guidance.

It also includes a helpful but much abbreviated description of the claims process that might be useful to you in addressing very simple straightforward questions about the plan and the process for claiming benefits.

See pages 36 to 39

A Step-by-step Guide to the Disability Claim Process

Source: Sun Life Financial 920-4370 (11-2003)

"HOW WILL I COPE?"

It is quite normal to experience uncertainty when you suffer a disabling accident, illness or injury. Disability insurance is intended to provide the Income replacement you will need if you are totally disabled and unable to work. This brochure takes you through the steps of a process designed to determine if you are entitled to benefits under the Disability Insurance Plan.

"WHAT SHOULD I DO?"

Read this brochure. It describes the steps in receiving, reviewing and communicating the details of your disability claim. Other services which may be critical to your longer-term needs are also explained. It's all in an attempt to ensure that your claim - and your future - is handled with care, and that you understand the disability claim process.

"WHAT DOES TOTALLY DISABLED MEAN?"

For the first 24 months of your continued absence from work, "totally disabled" means you have a physical or mental infirmity that prevents you from performing each and every ditty of your regular occupation or considered Totally disabled» if this continuous infirmity prevents you from performing the duties of a "commensurate job". A "commensurate job" is one for which you are (or become) qualified by education, training or experience. The pay rate for the commensurate job must equal at least two-thirds of the rate for your former job.

MEDICAL INFORMATION

A properly completed claim form, along with an attending Physician's Statement of Disability, are the first documents required. Depending on the situation, medical evidence could also include:

- a full narrative report from your doctor,
- reports from other doctors who have treated you,
- test results and their interpretation by medical experts,
- copies of medical and hospital records and
- copies of medical evidence submitted in support of a claim under the Public Service Superannuation Act (PSSA) or the CPP/QPP.

You are responsible for payment of certain charges for having medical forms completed. These forms include those described above,

supplementary medical statements, and any other forms that may have to be completed by a doctor in support of your claim.

PAYMENT OF BENEFITS

Sun Life will advise you immediately once your claim is approved. Your first benefit payment is due at the end of the month in which your elimination period ends, as detailes in the plan. If you wish, you can make arrangements to have your benefit payments deposited directly to your bank account.

Each January, benefits are adjusted in relation to increases in the Consumer Price Index. Payments are increased by a maximum of 3% annually.

To avoid overpayment of your disability benefits, you must advise Sun Life immediately if you:

- begin to receive other disability income,
- return to work, or
- might otherwise be ineligible for benefits. Benefits are not paid after age 65.

From time to time, depending on the medical evidence previously supplied, Sun Life will request updated medical evidence to ensure that you continue to be eligible for benefits. These additional evidence requests are kept to a minimum but they are essential to the ongoing assessment of your claim. You may receive a form to be completed by you and your doctor which must be returned to Sun Life. If necessary, Sun Life may write directly to your doctor.

THE APPEAL PROCESS

If your claim is denied again and you choose to appeal the decision by providing additional information, your claim will be reviewed at a more senior level in the Claims department.

If your claim is still not approved, there are two formal levels of appeal available to you:

First, you may request that your claim be reviewed by Sun Life's Group Disability Management Unit, composed of Medical Doctors and Senior Claims Analysts. This unit takes an independent approach to claims and

may overturn an earlier decision. It may arrange for you to be evaluated by an independent Medical Examiner, at Sun Life's expense.

If, following review by the Disability Management Unit, you wish to continue the appeal process, you may ask the Board of Management for the Plan to review your claim. This is the final avenue of appeal (with the exception of legal action). If you or your representative wish to have your claim referred to the Board of Management, you should write to: Secretary, Disability Insurance Plan Board of Management, National Joint Council, C.C. Howe Building, West Tower, 7th Floor, 240 Sparks Street, P.O. Box 1525, Station B, Ottawa, (ON) K1P 5V2.

Please include a brief explanation as to why you wish to appeal the decision on your claim. The Board meets approximately six times a year and the Secretary will contact you or your representative concerning its recommendations.

REHABILITATION

The Sun Life Rehabilitation Department is staffed by specialists who can provide personal assistance in many ways. Individuals with rehabilitative potential will be contacted by a Sun Life specialist who is committed to getting the rehabilitation process started as soon as possible. The key to rehabilitation is to prepare actively for a return to the work force while you receive ongoing financial support.

It is possible to return to work without jeopardizing your benefit payments. In fact, it's often appropriate to begin the process of returning to work by doing so on a part time basis. Sun Life also gets involved in educational and vocational restraining where required.

HOW YOUR DISABILITY INSURANCE CLAIM IS PROCESSED

STEP 1
CLAIM IS RECEIVED BY THE INSURER

The Insurer receives the following fully completed forms:

a) Employee Statement (TBS/SCT 330-302)
b) Employer's Statement (TBS/SCT 330-303)
c) Employee's Medical Information and Attending Physician's Statement (TBS/SCT 330-304)

Within five working days of receiving your claim, the Insurer will acknowledge receipt to you and begin evaluating your claim.

See "**Medical Information**" on page 36 above.

INCOMPLETE INFORMATION

If a decision cannot be made on your claim due to lack of information, the Insurer will notify you by letter.

Sun Life Assurance Company of Canada (the Insurer) and The Treasury Board of Canada

For more information:

Toll-free no: 1 800 361-5875

Fax toll-free no: 1 800 639-7849

Source: Sun Life Financial 920-4370 (11-2003)

STEP 2
CLAIM IS REVIEWED

Claims personnel and doctors examine your claim to see if you are eligible for disability benefits.

☑ Claim is approved, GO TO STEP 3.

☒ Claim is denied, GO TO STEP 2A.

STEP 2A
CLAIM IS DENIED

The Insurer will advise you that your claim has been denied, and will provide an outline of the type of medical information required for reconsideration of your claim as well as the options available for appealing the decision.

If you submit new medical information, your claim will be reconsidered by claims personnel and doctors.

See STEP 2B.

STEP 2B
THE APPEAL PROCESS

After the claims department's normal appeal process has been exhausted, a two step formal appeal process is available:

(1) The Insurer's Group Disability Management Unit. Senior claims officals and Medical Doctors consider the claim again and try to recommend courses of action which may be of assistance. If still denied, a letter will be sent to you. Without more comprehensive proof of total disability, your claim will not be examined further at this level.

(2) Board of Management for the Disability Insurance Plan. Public Service Management and bargaining agent representatives again consider the claim and may make recommendations to Sun Life. You will be notified of the outcome.

☑ Appeal is accepted, GO TO STEP 3.

☒ Appeal (1) is declined, may consider (2).

☒ Appeal (2) is declined. All normal avenues of appeal have been exhausted.

See "**The Appeal Process**" on pages 37-38 above.

STEP 3
CLAIM IS APPROVED

The Insurer will send you a letter providing all calculations, the date benefits will commence and how much you will be receiving.

See "**Payment of Benefits**" on page 37 above.

STEP 4
REHABILITATION

Where feasible, the Insurer will assist you to return to work or to find a new job. This assistance may include vocational training or counselling.

See "**Rehabilitation**" on page 38 above.

Chapter 6

Form Letter to Attending Physician/Specialist

Introduction

Chapter 6 includes a form letter to the attending specialist of physician asking that they provide more information or clearer information about the nature of the member's disability. Doctors tend to be very busy, and often skim through paperwork at the end of long days. Because Sun Life has a very narrow interpretation of disability it is important to encourage and help doctors to be as thorough as possible when filling out paperwork on behalf of the member.

File No. X

February 14, 2006

To Whom It May Concern:

Brother/Sister xx has asked me to intervene on his/her behalf concerning a decision taken by Sun Life Assurance Company of Canada to deny his/her claim for disability insurance benefits. Brother/Sister xx has recently provided me with related medical and non-medical documentation involving his/her case. I am writing to you to have this situation resolved in as expeditious a manner as possible.

In the last correspondence to Brother/Sister xx concerning his/her claim (Date), Sun Life suggested that his/her case would be reviewed again upon receipt of additional objective medical evidence. My past experience with the processing of disability insurance claims indicates that the provision of detailed information on the following will lead to the successful adjudication of his/her claim:

1. the nature, extent and severity of the disability condition (this would include references to significant symptoms where a diagnosis has yet to be determined);

2. the restrictions the disabling condition impose on the claimant in terms of his/her daily activities (e.g. ability to do household chores, ability to interact with others in social settings, participation in any sports or hobbies, attempts at rehabilitative employment or any alternate employment, limitations in walking, sitting, standing or tasks requiring extended periods of concentration, etc.);

3. how the restrictions identified above prevent the claimant from performing **each and every duty of his/her regular occupation/a commensurate occupation**;

4. the prognosis for the disabling condition;

5. the current treatment being undertaken by the claimant (e.g. frequency of visits for medical attention, current medical program, all prescribed medication along with respective doses, diet, exercise program, therapies, etc.);

6. any available supplementary documentation, such as

consultation notes, assessments and test results which would illuminate on the decline and/or deterioration in Brother/Sister xx's medical condition.

For your information, at the moment of becoming disabled, Brother/Sister xx was employed at (Department) as an (Occupation – Classification) and earning approximately (Salary) per annum.

The existing disability insurance contract includes the following definition of "Totally Disabled":

"An Employee is Totally Disabled if he/she is in a continuous state of incapacity due to Illness which

1. *while it continues during the Elimination Period and the following 24 months, prevents the Employee from performing each and every duty of his/her regular occupation or Employment.*

Loss or suspension of a license, due to Illness unrelated to alcoholism or drug addiction, which such Employee requires to carry out his/her regular occupation, will be considered Total Disability during the Elimination Period and the following 24 months, but only while such license continues to be withheld for the same reason.

2. *while it continues thereafter, prevents the Employee from engaging in any Commensurate Occupation for which he/she is or becomes reasonably qualified by education, training or experience.*

In no event, however, will an Employee be considered Totally Disabled if during any period he/she does not take part or co-operate in a Reasonable And Customary Treatment Program.

The term "Commensurate Occupation" is further defined as:
"An occupation for which the current salary or current rate of pay is not less than 66 2/3% of the then current salary for the Employee's own regular occupation."

In an effort to assist Brother/Sister xx in the approval of his/her disability benefits I would suggest that, as the attending physician/ specialist in this case, you provide Sun Life with the information as identified above, attesting to Brother/Sister xx's continuous incapacity to

perform the duties of his/her **own occupation**/**commensurate occupation** beyond (Date).

Would you please have all of the above documentation and information sent to the following address:

Health Insurance Claims
Sun Life of Canada,
P. O. Box 12500, Station CV,
Montreal, Quebec
H3C 4S3

In your correspondence please cite Brother/Sister xx's Contract # LTD 12500 and Certificate No. #CG#######.

I can assure you that should Sun Life fail to provide approval for Brother/Sister xx following receipt of the specified information above, I will have his/her case presented to the Disability Insurance Plan Board of Management forthwith. This latter Board serves as an independent forum for review of Sun Life decisions involving denial of disability benefits to individual claimants.

Please note that I understand that, as a health care professional, you have a very busy and hectic schedule and the effort to provide the information required in this case can be a time-consuming and tedious affair. However, I am convinced, as I believe you are, that Brother/Sister xx is legitimately entitled to disability insurance benefits and deserves appropriate representation.

Please be advised that any cost associated with the provision of this information is the responsibility of Brother/Sister xx.

I trust you will find the above acceptable and should you have further questions or require any clarifications, please do not hesitate to contact me at (zzz) zzz-zzzz.

Sincerely,

PSAC Local Officer
PSAC Local Officer Title

Chapter 7

Guide to Third Party Medical Evaluation

Introduction

Chapter 7 contains a document produced by the Canadian Society of Medical Evaluators called a Guide to Third Party Medical Evaluation. It provides a rule of ethical conduct to be used by CSME members for the purpose of third party medical evaluations. Members are often instructed to attain third party evaluation as a condition of their claim.

We include this document simply to highlight the role of a doctor who is doing third party medical evaluations compared to the role of your family physician or attending specialist. The medical evaluator's role is quite different as is his/her mandate. Members and member advisors should be aware of those differences.

See pages 45 to 49

Canadian society of medical Evaluators

GUIDE TO THIRD PARTY MEDICAL EVALUATION

(Adapted from the *Guide de L'Expertise Médicale de la Société des Médecins Experts du Québec*) Revised April 2004

Preamble:

The Guide to Third Party Medical Evaluation provides rules of ethical conduct to be used by all CSME members for the purpose of third party medical evaluation.

SECTION I
General Duties

1.1 Medical evaluators shall conform to the code of ethics, scope of practice and regulations of their professional college.

1.2 Medical evaluators have the responsibility to provide high quality services. They shall take into account their knowledge, skills, qualifications, training and experience, and shall recognize their limitations. Medical evaluators shall abstain from performing evaluations or providing opinions outside their area of expertise and respect the mandate provided by the referring source.

1.3 Medical evaluators shall abstain from participating in inappropriate publicity or promotion.

1.4 Medical evaluators must retain absolute professional independence from the referring source requesting the evaluation. Medical evaluators have an obligation to remain impartial and must have no stake in the outcome of the medical evaluation.

1.5 Medical evaluators shall not issue any report or document containing information that they know to be false or inaccurate.

1.6 Medical evaluators shall request remuneration fro their services commensurate with the duration and complexity of the evaluation. Other forms of financial arrangements are not acceptable.

Medical Evaluation Standards

1.7 Before agreeing to perform a referring source medical evaluation, it is highly advisable that medical evaluators obtain a referral letter outlining the scope and purpose of the evaluation along with the relevant documentation.

1.8 Medical evaluators shall refrain from providing opinions on the degree of permanent impairment resulting from bodily injury or illness that has yet to have reached maximal medical improvement.

1.9 Medical evaluators who render opinions before the residual effects (sequelae) of an injury or illness become stabilized and permanent shall indicate that such opinions are preliminary.

1.10 If no impairment is found in the course of the medical evaluation, medical evaluators shall indicate it in their report.

1.11 A final opinion on impairment shall not be made until the impairment has consolidated and stabilized.

1.12 Medical evaluators shall establish their conclusions and opinions based on the objective findings of the evaluation with reference to recognized medical standards approved by the SCME. If the medical evaluator judges that it is appropriate to depart from these standards, mention of such action must be made in the report, stating the reason for the decision.

1.13 Medical evaluations should be written within a reasonable time following the examination and fall within the legislated prescribed time frame.

1.14 Medical evaluators who perform medical evaluations also accept the responsibility to act as expert witnesses in court or in administrative tribunals upon the request of one of the parties or the court in order to explain or defend their evaluations. Remuneration should be commensurate with the duration and complexity of services provided.

1.15 Medical evaluators must demonstrate the greatest possible objectivity by taking into account all elements obtained at the time of the evaluation and contained in the documentation provided from any source. If medical evaluators realize that they were not provided with all documents, they should ask for them or at least mention the fact in the report.

1.16 Medical evaluators must ensure that any conflict of interest must be declared prior to agreeing to perform a medical evaluation. The referring source and claimant, after being made aware, must agree to the assessment.

1.17 If medical evaluators disagree with the treatment or diagnosis provided by treating physicians, they must not assume a role in the treatment. However, if facts or errors are identified which could jeopardize the life or health of the claimant, medical evaluators have the duty to inform the treating physician(s) of the situation after having obtained the appropriate authorization. In such circumstances, medical evaluators remain subject to the code of ethics and regulations of their professional college.

1.18 Medical evaluation reports can only be provided to the referring source that made the request unless legislation requires otherwise.

1.19 Medical evaluators accept that their opinion may be disputed, even in court. To defend their opinions, they must use only the objective facts and scientific arguments in keeping with the generally accepted medical knowledge.

Duties Toward Claimants

2.1 Medical evaluators must inform claimants of the nature, process and purpose of the medical evaluation. The referring source requesting the medical evaluation should also be identified to the claimant. The difference between the role of medical evaluators and treating physicians should be explained to claimants.

2.2 Medical evaluators shall abstain from discussing with claimants information or opinions irrelevant too the evaluation.

2.3 Medical evaluators shall abstain from making any comments or actions during the evaluation that could jeopardize claimants' trust in their treating physicians and other health professionals.

Preamble: Medical evaluators may be required to be alone with a claimant at some time during the history taking or the examination

2.4 Medical evaluators must respect the modesty and dignity of claimants. In this regard, guidelines of the Colleges of Physicians and Surgeons should be followed.

2.4.1 Medical evaluators must avoid any use of unprofessional comments or gestures, sexual or otherwise.

2.4.2 Medical evaluators must demonstrate and maintain a professional attitude and behavior throughout the evaluation.

2.4.3 Medical evaluators shall identify themselves and their evaluation staff to the claimants.

SECTION III
Duties Toward other Physicians

3.1 In their reports, medical evaluators shall address the issues relevant to the purpose of the evaluation. Disagreements with medical colleagues or other health professionals should be clearly based on and confined to objective evidence and inferences drawn from it and only in keeping with the generally accepted medical knowledge.

SECTION IV
Duties Toward the CSME

4.1 Medical evaluators shall support the goals and standards of the CSME.

4.2 All CSME members shall participate in and be subject to a regular peer review process. All CSME members shall be required to evaluate the medical evaluation reports of membership applicants or peers to determine their conformance to the CSME standards. They shall do no less than two peer reviews per year upon request by the Executive.

4.3 Any active CSME member endorsing applicant for membership in CSME shall:

a) have sufficient knowledge of the applicant to know that the individual will be compliant with the standards, and

b) review in depth two medical evaluation reports of the membership applicant and certify that they comply with the CSME standards.

Chapter 8

Authorization for Release of Information form

Introduction

This chapter consists of the National Joint Council (NJC) Authorization for Release of Information form.

If a member's disability insurance claim and their appeal to the insurer is rejected the member's claim can be referred to the Disability Insurance Plan Board of Management. In order to make this referral an Authorization for Release of Information form needs to be filled. This form authorizes the Insurer (Sun Life) to release all necessary confidential information to the Board, including medical reports which Sun Life has at its disposal. The form is available from the Human Resources section of the department with whom the member is employed. Components and PSAC regional offices should also have copies of this form on hand.

If possible, you should advise members in the development of their submission. At this point in the process it is also advisable to consult with the Pension and Disability Insurance officer of the PSAC, both for additional information on case preparation and to alert the PSAC in Ottawa that the case will be referred to the Board of Management.

National Joint Council of the Public Service of Canada

Conseil national mixte de la fonction publique du Canada

AUTHORISATION FOR RELEASE OF INFORMATION

I hereby authorise and direct that Sun Life Assurance Company of Canada (hereinafter referred to as "Sun Life") allow the Disability Insurance Plan Board of Management (or person authorised to act on its behalf) to review information, including medical reports, on my claim for disability benefits under the Disability Insurance Plan (Sun Life's group policy number 12500-G).

I give this authorisation on the understanding the information shall be used solely for the purpose of the Board of Management consideration of my appeal and shall not under any circumstances be disclosed to any person not involved in such consideration. If documents belonging to Sun Life are made available to the Board of Management, it is understood such documents remain the sole property of Sun Life and that no copies shall be made. The Board of Management (or the person authorised to act on its behalf) is directed to return to Sun Life any and all documents so obtained immediately upon completion of the consideration of my appeal by the Board of Management, at which time this authorisation expires.

Dated this _______ day of __________ ,2007

AUTORISATION DE DIVULGUER DES RENSEIGNEMENTS

Par la présente, je donne à Sun Life du Canada, compagnie d'assurance-vie (ci-après appelée la Sun Life) l'autorisation et l'ordre de permettre au Conseil de gestion du régime d'assurance- invalidité (ou toute personne autorisée à agir en son nom) d'examiner les renseignements, y compris les certificats médicaux, concernant ma demande de prestations d'invalidité aux termes du Régime d'assurance-invalidité (police collective numéro 12500-G de la Sun Life).

Je donne cette autorisation à condition que ces renseignements soient utilisés uniquement pour l'examen de mon appel par le Conseil de gestion et qu'ils ne seront divulgués en aucun cas à des personnes qui ne participent pas à cet examen. Par ailleurs, il est entendu que tout document appartenant à la Sun Life et qui est mis à la disposition du Conseil de gestion demeure la propriété exclusive de la Sun Life et qu'aucune copie ne sera faite de ce document. Le Conseil de gestion (ou la personne autorisée à agir en son nom) a l'ordre de renvoyer à la Sun Life tout document ainsi obtenu aussitôt que le Conseil de gestion aura terminé l'examen de mon appel, entraînant par le fait même l'expiration de la présente autorisation.

Le ______ jour de _________________ 2003

____

Name of Claimant/Nom du (de la) réclamant(e)

(Please print / Écrire en lettres moulées)

____

Signature of Claimant/Signature du (de la) réclamant(e)

____

Claim number/
Numéro de la réclamation

P.O. Box 1525, Station B
Ottawa, Ontario K1P 5V2

C.P. 1525, Succursale B
Ottawa (Ontario) K1P 5V2

Chapter 9

Termination of Employment due to Disability

Introduction to Chapters 9,10 and 11

These chapters contain background information and concrete advice on the actions you can take if your employment is terminated because you have a disability.

Included are:

An introductory letter from PSAC National President Nycole Turmel

Chapter 9: Information on grievances and grievance wording you can submit

Chapter 10: Information that you need to know if you should also wish to file a human rights complaint.

Chapter 11: Information on the relationship between your right to grieve and your rights under the Canadian Human Rights Act, and

See pages 53 to 65

April 21, 2003

To: PSAC Component Head Offices
PSAC Component National Officers
PSAC Locals
PSAC Regional Offices
Members with Disabilities Ad Hoc Committees
National Board of Directors

Re: **Termination of Employment with Treasury Board Due to Disability**

Since 1996, Treasury Board and the agencies under its control have had a policy of terminating employees who are on Disability Insurance for more than two years (see Information Bulletin of September 23,1996). The most current information on a strategy to best protect our members' rights in such cases is attached.

At this writing, changes to public service legislation are under consideration. We do not know the final wording or the implementation dates at this time nor do we know how the legislation will impact on Disability Rights at this time. Please watch the PSAC website for updates. The same is true for lead cases. We have CHRC Tribunal and court challenges in play, which could have a major impact on members' rights in the area of disability, accommodation, human rights legislation and Supreme Court cases.

The best advice we can give you today is that the 'bounce-back' procedure for dealing with human rights issues is still in place, although the proposed new changes to Public Service labour legislation would give power to adjudicators to rule on human rights issues. Currently, PSAC members under the *Public Service Staff Relations Act* do not have direct access to the grievance procedure with respect to human rights related

issues. However, there is indirect access to the grievance procedure through the Canadian Human Rights Commission. A member must file a human rights complaint and request that the Commission "bounce back" or send the complaint to be processed through the grievance procedure. If this occurs, then the employer has agreed to process human rights related grievances. It is important to note that the Commission has discretion whether to send a complaint back to the employer or not. (See the cited bulletin on the PSAC Representation web site - http://www.psac.com/what/representation/27-e.shtml).

We advise that you use the attached information to inform and assist members caught by this very unfair employer termination policy. It outlines the procedures to follow, and summarizes the financial and employment impact of different outcomes to the attempted termination.

If you require further information, please note the available reference points at the end of the letter

In solidarity,

Nycole Turmel
National President.

Termination of Employment by Treasury Board Due to Disability

Dear Brothers and Sisters:

Since 1997 Treasury Board has authorized departments to send letters to employees directing that they must either return to work or end their employment with the federal government. In almost all instances these letters are being sent to employees who left the workplace due to disability and have been on Leave without Pay status usually for two years or longer. If employees are unable to return to work, they are then offered the option of either terminating their employment (quitting or being fired) or choosing to go on medical retirement. Departments who have since become agencies have mirrored this practice.

The PSAC is appalled that Treasury Board and agencies still continue to condone this practice. While it seems to allow employees to voluntarily choose to end their employment, they have in fact been forced to leave. We are particularly concerned that this forced termination targets workers with a disability, which flies in the face of the duty to accommodate as set out in human rights legislation. It is of additional concern to us that Sun Life and National Life records are apparently being used to target these employees. We have raised these concerns with Treasury Board and he agencies repeatedly, to no avail. We have consistently raised this matter with Treasury Board over the last five years. It is our view that Treasury Board should immediately rescind this extremely unfair and prejudicial policy.

We are of the firm opinion that it is not an "Undue hardship" (e.g., too expensive or too difficult) for the employer to simply allow employees in this situation to continue on Leave Without Pay Status. On the other hand, it could be quite a hardship on individual employees to be forced into quitting or onto medical retirement. The PSAC continues to contest this policy.

In the meantime, we believe that those faced with this situation should be provided with sufficient information to allow an informed choice. In the attached chart we have shown what would happen in terms of both short term and long term benefits and pension rights for an employee who

(a) is terminated.
(b) takes medical retirement.
(c) remains on an indefinite leave without pay status.

As you can see, the options produce very different results and, in all cases, the least penalizing option is to remain on Leave without Pay.

We recommend grievance action be taken. However, a major concern of ours is that, **as with any grievance, there is no guarantee that the griever will win** and, in this situation, the griever could stand to lose a lot. Thus, we are outlining various responses in the event you find yourself in the above situation. It is extremely important, for your own financial security, that you fully review the attached chart and, in consideration of your own situation, choose the option best suited to your needs. Each option has its benefits and its potential risks. Where grievances are lodged, the Alliance will provide representation with the caution noted above.

A) Where an employer has requested an employee on Leave without Pay that results from a disability to clarify her/his situation

The employee should clarify in writing that s/he wishes to remain on Leave without Pay status.

B) Where an employee has received an initial letter or verbal communication requesting s/he choose either to return to work or in some manner terminate employment

The employee should grieve the receipt of this letter or verbal communication clearly stating the employee's wish to remain on Leave without Pay status and that the corrective action sought is the retraction of the demand to choose amongst these options. The grievance should be worded as follows:

> *I grieve the employer's [letter or verbal communication] of (date) which requests that I either return to work or in some manner terminate my employment. This is intimidation and discrimination based on disability. It is contrary to the employer's obligations under the collective agreement and the Canadian Human Rights Act*

<u>Corrective Action</u>:

1. That the employer withdraws its request and not make similar requests in the future.

2. That / be accommodated by being allowed to remain on LWOP status until I am able to return to work.

3. That I be made whole.

C) Where the employer has pursued the matter and the employee will be terminated if they do not choose to resign or to apply for medical retirement

<u>In this situation we will outline two possible approaches to submitting a grievance.</u> Whichever option you choose, please note that medical retirement is not automatic and requires an application/approval process. Sometimes this process can be quite quick (4 - 6 weeks), but it can also take months. There is no guarantee that the employee will be granted medical retirement at the end of this process.

Medical retirement can be taken, upon approval, by any employee at any age, but your ultimate pension benefit is based on your years of pensionable service. Thus, the shorter the time you worked for the employer, the lower your pension.

If you are on Disability Insurance, you receive 70% of your salary. If you are granted a medical pension and the pension benefits are Less than 70% of your salary, the Disability Insurance program will provide a top-up to 70%. Disability Insurance benefits end when you turn 65 years of age and you will be left with your medical retirement pension and whatever other sources of income to which you may have access.

The difference between termination and medical retirement is significant. It can be quite significant in terms of eligibility for benefits and the resulting consequences. It is especially significant in terms of eligibility for health care and supplementary death benefit (SDB) coverage. This is particularly

the case for members who are under the age of 50. The attached chart provides further and more detailed information on this important distinction.

Option 1:

In this option the employee chooses medical retirement, but in their written response makes if very clear that they are doing so under duress and without prejudice to the grievance. The application for medical retirement should also be signed with the added proviso of "Without prejudice to my grievance against termination". As well, it should also be made clear that the employee would prefer to remain on Leave without Pay status. A grievance should be filed and worded as follows:

I grieve the forced termination of my employment by the employer's letter (or verbal communication) to me of (date). I have applied for medical retirement in order to preserve important rights, but this was done under clear duress and without prejudice to the present grievance against termination. The employer's actions in this matter deprive me of collective agreement benefits and constitute discrimination contrary to the Canadian Human Rights Act and the collective agreement

Corrective Action:

1. *That the employer withdraws it's forced termination of my employment.*

2. *That I be accommodated by being allowed to remain on LWOP status until I am able to return to work*

3. *That my rights to the Federal Dental Plan and all other benefits dependent on employee status be preserved and protected.*

4. *That I be made whole.*

This option should be seriously considered by an employee who is not already of retirement age and who does not have access to an alternate health care benefit program, e.g., through a spouse or another source.

Option 2

In this option, the employee refuses to make a choice and the employer terminates her/him. The employee then grieves the termination with the following wording:

I grieve the employer's termination of my employment by its letter of (date). This constitutes discrimination contrary to my collective agreement and the Canadian Human Rights Act.

Corrective Action:

1. That the employer retracts the termination of my employment.

2. That I be accommodated by being allowed to remain on LWOP status until I am able to return to work.

3. That I be made whole.

Following termination, the employee should apply for medical retirement, with the application for medical retirement signed with the qualification **"Without prejudice to my grievance against termination".**

This option should be seriously considered by an employee who is already of retirement age or, who, though not of retirement age, **has access to** an alternate health care benefit program, e.g., through a spouse or another source. Please also note that depending on the results of the application for medical retirement, this option could have implications on the cost and availability of supplementary death benefit coverage.

Canadian Human Rights Commission Complaint

As well as the above grievances, we strongly recommend that you lodge a complaint with Canadian Human Rights Commission stating that your termination was based solely on disability. This complaint will be held

pending a decision in the above grievance(s), but may ultimately provide you with the best recourse.

Before you take any action, contact a union representative to discuss your options. Questions about the wording of the grievance should be directed to your Local steward, who may then wish to contact the Component or the PSAC Regional Office. Component and Regional Offices may also contact the Grievance and Adjudication section for advice. Further information about benefits is available from:

James Infantino
Research Officer
Pensions and Disability Insurance
(613) 560-4215.

Complaints of this nature constitute a developing area of the law. We would request that you advise us of any grievances or complaints filed in these situations, through the:

PSAC Human Rights Office
233 Gilmour Street
Suite 901
Ottawa ON K2P OP1

We wish you the best of luck. Please rest assured that our union is working on behalf of our members with disabilities to ensure that they are accommodated and treated in a non-discriminatory manner.

EMPLOYEE BENEFIT ENTITLEMENTS UNDER RELEASE FOR INCAPACITY/RESIGNATION, MEDICAL RETIREMENT AND MAINTENANCE OF EMPLOYMENT THROUGH THE PROVISION OF LEAVE WITHOUT PAY STATUS

This chart is intended to provide an overview of the benefits and pension available In different scenarios. It does not provide full details and you should check with your pay and benefits office for specific information on your personal situation. See the final page of this chart for some examples of typical cases.

Release for Incapacity / Resignation	**Medical Retirement**	**Maintenance of Employment through the provision of leave without pay status**
Public Service Superannuation Act		
• Pension is based on years of service X 2% of the salary the employee had for his/her best consecutive five years of earnings. Thus, if s/he had worked for 10 years, s/he would be eligible for a pension that is 20% of his/her salary, subject to a reduction depending on the employees age and/or years of service. • Employee must have at least 2 years service to be eligible for a pension • If employee is over age 50, s/he can immediately retire, either at full pension (age 60 years, 55 with 30 years service) or at age 50 with a reduced pension. • If employee is under age 50, no pension is payable. Must wait until at lease age 50 to claim pension at the rates noted above.	• Pension is based on years of service X 2% of the salary the employee had for his/her best consecutive five years of earnings. Thus, If s/he had worked for 10 years, s/he would be eligible for a pension that is 20% of his/her salary. • Employee must have at least 2 years service to be eligible for a pension. • Employee can be any age to be eligible to receive an immediate unreduced pension. • If the employee is receiving Disability Insurance, it will be reduced by the amount of his/her pension (e.g. Employee receives 70% of salary while on DI. If the pension is 20% employee will receive 50% DI)	• Eventual pension is based on years of service X 2% of the salary the employee had for his/her best consecutive five years of earnings. • Employee must have at least 2 years service to be eligible for a pension • Employee will continue accumulating years of service for the duration of the leave without pay period**.** • Employee will be allowed to include such leave as pensionable service if s/he buys back the years at 7.5% of the annual salary for each year.

Release for Incapacity/ Resignation	Medical Retirement	Maintenance of Employment through the provision of leave without Pay status
	Supplementary Death Benefits	
• Employees can continue to maintain their benefits by paying a premium. The rates for the premium are different for those claiming a pension and those not claiming a pension, with the latter rates being significantly higher (e.g., in the one case identified over $1,000 more per year).	• Employees, can continue to maintain their benefit by paying a premium at the "normal" or lower rate.	• Employee must continue paying the premiums for SDB while on leave without pay. • Employees will pay the premium at the "normal" employee or lower rate
	Public Service Dental Care Plan	
• Coverage discontinued on termination	• Coverage discontinued on retirement.	• Coverage is continued while on Leave without Pay. • No employee contributions are required.
	Pensioners Dental Service Plan	
• If the employee is in receipt of a pension benefit, membership in the Pensioners Dental Services Plan permitted at the following premium rates: • Pensioner Only - $16.00 per month • Pensioner and one eligible family member - $31.96 per month • Pensioner and more than one eligible family member - $47.96 per month	• Employee is eligible for participation in the pensioners Dental Services Plan at the following premium rate: • Pensioners Only - $16.00 per month • Pensioners and one Eligible family members -$31.96 per month • Pensioner and more than one eligible family member - $47.96 per month	• Not necessary

<table>
<tr><th>Release for Incapacity/ Resignation</th><th>Medical Retirement</th><th>Maintenance of Employment through the provision of leave without pay status</th></tr>
<tr><td colspan="3">Public Service Health Care Plan (PSHCP)</td></tr>
<tr><td>• Coverage discontinued unless the employee is receiving a pension, in which case the employee may retain coverage at the pensioner premium rates.</td><td>• Employee may continue coverage at the pensioner premium rates</td><td>• Employees may continue coverage provided they submit employees share of contributions while on leave
• The employees share varies, but does not exceed $10.34 per month and may require no contribution at all depending on level of coverage chosen.</td></tr>
<tr><td colspan="3">Severance Pay</td></tr>
<tr><td>Incapacity
• Employee receives one week's pay for each completed year up to 28 years
• The employee must have completed more than one year's service and have been released for incapacity under the Financial Administration Act.
Resignation
• Employee receives one half week's pay for each completed year up to a maximum of 26 years with a benefit of 13 weeks pay.
• Employee must have completed 10 or more years of service.</td><td>• Employee receives one week's pay for each completed year up to 30 years and the portion of a week's pay based on partially completed year.</td><td>• Employee will continue to accumulate years of service while on leave without pay (for medical reasons) and these years would be included in the determination of the employee's severance package.
• The rate of pay of an employee's substantive position on the date of termination or employment would be used for severance calculations.</td></tr>
</table>

Release for Incapacity/ Resignation	Medical Retirement	Maintenance of Employment through the provision of leave without pay status
Case Studies ***MARY*** ***Mary is 30 years old with 6 years of service. She is single with no dependants. She has been on Disability Insurance for two years. At the time of her disability, Mary was earning $30,000 per year.***		
• No pension is payable. Mary will receive 12% of the annual salary for her best consecutive five years, at the earliest at age 50 (it would then be a reduced pension). • To continue her supplementary death benefits, Mary will have to pay an annual premium of $342.60 • Mary's Dental Care Plan coverage will be discontinued. • Mary's Health Care Plan coverage will be discontinued. • If Mary is released for incapacity, she will be entitled to 6 weeks of severance pay. If Mary resigns, she will receive no severance pay. (see Tip #5 on sources of income during disability)	• Mary will receive 12% of the annual salary for her best consecutive five years • To continue her supplementary death benefits, Mary would have to pay an annual premium of $108.00 • Mary's Dental Care Plan Coverage will be discontinued. However she can participate in the Pensioners Dental Services Plan at a premium rate of $16.00 per month • Mary's Health Care Plan Coverage can be maintained at a monthly rate of $9.01 for Level I (basic) • Mary will receive severance pay of 6 weeks salary.	• Mary will continue accumulating years of service while she remains on leave without pay. If she is able to remain in this status until she is age 65 and she buys back the years of service, she will receive 70% of her salary for her best consecutive five years as a pension • Mary must pay an annual premium of $108.00 which will continue her supplementary death benefits. • Mary's Dental Care Plan coverage will be continued at no cost. • Mary's Health Care Plan coverage (Level I, basic) will be continued at no cost. • Mary will continue to accumulate years of service while on leave without pay. If she remains in this status until age 65, as above, she will receive 30 weeks of severance pay.

Release for Incapacity/ Resignation	Medical Retirement	Maintenance of Employment through the provision of Leave without Pay status
Harminder **Harminder is 53 years of age and has 15 years of service. He is received Disability Insurance and has been on leave without pay for 3 years. He is married and has 3 children who still attend school. At the time of disability, Harminder was earning $45,000 per year.**		
• Harminder can choose to receive an immediate pension. His pension would be 30% of the annual salary for his five best consecutive years. As he is retiring early, however, this pension will be reduced by 35% (age 60 – 53 = 7 X 5%). If he elects this option, his health care, supplementary death benefits and severance pay will be the same as under the Medical Retirement column. • Harminder can also choose to defer receipt of his pension until age 60 and receive a full pension of 30% of the salary of his five best consecutive years, his benefits will be: • Harminder's Dental Care Plan coverage will be discontinued. • Harminder's Health Care Plan coverage will be discontinued. • Regardless of whether Harminder is released for incapacity or he resigns, he will be entitled to severance pay of 15 weeks salary	• Harminder will receive a pension of 30% of the annual salary for his best consecutive five years. • To continue his supplementary death benefits, Harminder will have to pay an annual premium of $162.00 • Harminder's Dental Care Plan coverage will be discontinued. However, he can participate in the Pensioners Dental Services Plan at a premium rate of $47.96 per month • Harminder may continue coverage under the Health Care Plan. The monthly premium for basic family coverage will be $17.66 • Harminder will receive severance pay of 15 weeks salary.	• Harminder will continue accumulating years of service while he remains on leave without pay. If he is able to remain in this status until he is age 65 and he buys back the years of service, he will receive 54% of his salary for his best consecutive five years as a pension. • Harminder must pay an annual premium of $162.00, which will continue his supplementary death benefits. • Harminder's Dental Care Plan coverage will be continued at no cost. • Harminder's Health Care Plan coverage, for himself and his family, can be continued at no cost. • Harminder will continue to accumulate years of service while on Leave Without Pay. If he remains in the status until age 65, as above, he will receive 27 weeks of severance pay.

Chapter 10

Lodging a Canadian Human Rights Commission Complaint

Introduction to Chapters 9,10 and 11

These chapters contain background information and concrete advice on the actions you can take if your employment is terminated because you have a disability.

Included are:

An introductory letter from PSAC National President Nycole Turmel

Chapter 9: Information on grievances and grievance wording you can submit

Chapter 10: Information that you need to know if you should also wish to file a human rights complaint.
http://www.psac-afpc.com/what/representation/26-e.shtml

Chapter 11: Information on the relationship between your right to grieve and your rights under the Canadian Human Rights Act, and

See pages 67 to 75

Guidelines for the presentation of complaints to the Canadian Human Rights Commission for PSAC members

I Introduction

PSAC members who are subjected to discriminatory practices contrary to the *Canadian Human Rights Act* may present complaints under that *Act* in order to seek redress. PSAC believes that an understanding of the process before the Commission, and the nature of the evidence required, will assist PSAC members in maximizing the chance of succeeding with a complaint. Accordingly, PSAC has prepared these guidelines for its members to assist in pursuing a human rights complaint.

II Overview of the Jurisdiction of the Canadian Human Rights Commission

The Canadian Human Rights Commission is established pursuant to the *Canadian Human Rights Act.* Its primary function is to pursue the goal of eradicating discriminatory practices of employers and service providers which are regulated by the Federal Parliament. This would include the Federal Government and its departments and agencies, crown corporations such as Canada Post, chartered banks, national airlines, interprovincial communications and telephone companies, interprovincial transportation companies and other federally regulated industries.

It is important to understand that the Commission has a variety of roles under the *Canadian Human Rights Act*. Two primary roles which a complainant should be concerned about is the investigator role and the screening role.

When a complaint is presented, the Commission essentially acts as an investigator. In this role, the Commission assigns a person who will look into the complaint and ultimately make recommendations regarding how it should be dealt with.

Once the investigation is complete, however, the Commission takes on a screening function. This function is actually performed by the members of the Commission appointed under the *Canadian Human Rights Act*. Their role is to determine whether an inquiry into the complaint by an independent Tribunal is necessary. Generally, if there is a reasonable basis in the evidence supporting the complaint, the Commissioners will decide to refer the complaint to Tribunal for a decision and for an appropriate remedy. The Commissioners themselves do not have the authority to order a remedy for the complainant.

Studies have determined that approximately four to six percent of all complaints filed with the Commission actually get referred to a tribunal for a decision. While many of those complaints not referred are settled or are determined to be outside of the Commission's jurisdiction, a large proportion of them are dismissed on the basis of the Commission's conclusion that no discrimination in fact occurred. When you present a Human Rights Complaint, you should ensure that all of the evidence that you have in support of your allegations are presented to the Commission. In Parts IV and V, below, we identify in more detail our suggestions as to what should be presented to the Commission in order to maximize the chance that the complaint will be referred to a Tribunal.

III Description of the Commission Process

Broadly speaking, the Commission process can be divided into the following phases:

(a) Intake;

(b) Investigation;

(c) Disclosure and Submissions; and

(d) Consideration of Complaint by the Commission.

(a) **Intake**

(1) The intake stage follows the initial contact with the Commission. At this point, the Commission determines on a preliminary basis whether it has jurisdiction to consider the complaint. Pursuant to s. 41 of the *Act*, the Commission may decline to investigate the complaint where it determines that the complainant ought to exhaust grievance or review procedures

otherwise reasonably available, that the complaint should be dealt with according to another procedure provided for under an Act of Parliament, that the complaint is trivial, frivolous, vexatious or made in bad faith or that the complaint relates to acts or omissions which are more than one year old.

(2) With respect to this last issue, the Commission can, in proper cases, consider complaints respecting events that are more than one year old. This could occur, for example, where the complainant was unaware of the particular circumstances or where the complainant had attempted to get a remedy elsewhere prior to going to the Commission. In all cases, it is advisable to at least contact the Commission within the one year time period so that you can establish an intention to pursue a complaint at that time.

(3) Eventually, you will be required to prepare and sign a complaint form. The complaint form need not be a lengthy and detailed description of the allegations. Rather, it is designed to be a general identification of the incidents complained of and the grounds for discrimination. Complaint forms are often amended when new information comes to light.

(4) Once the complaint is accepted by the Commission, it will assign the matter to an investigator. Recently, the Commission has undertaken a program to conduct mediation prior to the investigation. Mediation is a process where a neutral third party attempts to assist the parties to settle a complaint. Participating in mediation is voluntary. Mediation will often result in a settlement without having to use the resources of an investigation process.

(b) **Investigation**

(1) The investigator's initial task is to gather and analyse all of the evidence pertaining to the complaint. This not only includes documentary evidence but may involve interviewing witnesses who have been identified by the parties as having relevant information. The Courts have confirmed that investigators do not have to interview every single witness identified by the parties. It is usually sufficient if the investigator interviews the key persons involved in the incidents which give rise to the complaint. The Courts have also confirmed that the investigation itself must be fair and thorough.

(2) In some cases, a legal issue may arise respecting the complaint. Often the Commission will refer the matter to its legal services section to obtain an opinion or advice on how to address a particular point of law. The Commission is not required to share the legal opinion provided by its lawyers with the complainant or the respondent as it may be subject to privilege between a lawyer and client.

(3) Once the investigation is complete, the investigator prepares an investigation report and provides it to the parties. The investigation report generally follows a standard format which includes a summary of the allegations and the complainant's position, a summary of the respondent's position, a description of the evidence considered by the investigator, a discussion, if necessary, of any legal issues raised by the complaint, and an analysis of the basis for the complaint.

(4) At the end of the report, the investigator will recommend whether the complaint should be put on hold pending another event, dismissed, referred to conciliation, or referred to a tribunal. Conciliation is, like mediation, a process which is designed to assist the parties to settle the complaint with the help of an independent third party.

(c) **Disclosure and Submissions**

(1) Once the investigation report is completed, the report is disclosed to the parties. The report is normally accompanied by a standard letter from the Commission inviting each party, if they so choose, to provide submissions on the investigation report. This is an important opportunity for the parties to address the evidence, analysis, or findings contained in the investigation report as any submissions with respect to the report will be provided to the Commissioners. It is important to remember that the report and the material you submit are the basis upon which the Commissioners will determine whether to refer your complaint to an independent Tribunal.

(2) Where the parties' submissions on the report contain new evidence or arguments, they are required to be disclosed to the opposing party for further comment. In these circumstances, the party would have another opportunity to reply to the new submissions. As with the initial submission, these submissions will be provided to the Commission when it considers the complaint.

(d) **Consideration of Complaint by the Commission**

(1) Following the investigation, the Commission will decide how to deal with the complaint. The Commission members are provided with a copy of the investigation report and the parties' submissions. The Commission may also have access to any legal opinions provided by the Commission's legal services unit respecting the legal issues raised by the complaint.

(2) Complaints are considered by meetings of the Commissioners which are scheduled on a regular basis. Neither the complainant nor the respondent are present at these meetings. It is usually the case that the Commissioners will consider a large number of complaints in the space of a short period of time. However, the Commissioners are usually provided with materials in advance of the meeting for their review.

(3) The Commission is not required to accept a recommendation of the investigator. In addition to holding the complaint, dismissing the complaint, referring the complaint to conciliation, or referring the complaint to tribunal, the Commission may decide to refer the complaint back for further investigation. This may occur where the Commission believes that more investigation is required.

(e) **After the Commission Decision**

(1) After the Commission renders its decision, the parties are informed by a letter from the Secretary of the Commission.

(2) In the event the Commission determines that the complaint should be referred to a tribunal, the President of the Canadian Human Rights Tribunal will, in due course, appoint a tribunal to inquire into the complaint. The Canadian Human Rights Tribunal is a separate entity from the Commission.

(3) In the event the Commission refers a complaint to a conciliator, a conciliator will be appointed to attempt to settle the complaint. The conciliator is often an employee of the Commission who is trained in the area of conciliation. If the conciliation does not result in a settlement, the matter is referred back to the Commission for a further decision as to how to dispose of the complaint. At this stage the parties will be given another opportunity to make submissions regarding the complaint.

(4) For more particular information regarding the process before the Canadian Human Rights Commission, the Commission provides such information generally and on its web site.

IV What to Submit

While the foregoing summarizes the process before the Commission at various stages, it does not address the substance of the information or evidence which should be presented to the Commission at each stage. The following are some guidelines respecting what you should submit to the Commission.

(a) **Intake Stage**

(1) At this stage, it is important to provide as much detail as possible regarding the basis for your complaint. For example, if you believe that a supervisor has made a critical comment of you based upon your race, you should provide as much information regarding the incident including who made the comment, when it was made, how it was made, who witnessed it, etc.

(2) In many instances, discrimination is not documented. As a result, it is very important for you to keep a record in writing of what has transpired which you believe is discriminatory. Not only will this assist the investigator in looking at the complaint, it will also assist you in remembering what may have happened in the past. In some cases, the investigation of a complaint can take months or years. It is imperative therefore to do whatever you can to ensure that the evidence is remembered and is as accurate as possible.

(b) **Investigation Stage**

(1) Throughout the investigation stage, the investigator may discuss the evidence with you to clarify what it is or to determine whether any other evidence exists. You should attempt to keep the investigator as informed as possible regarding any new information you may obtain or recall. It is strongly recommended that the communication of such information to the investigator be confirmed in writing.

(2) Moreover, where you believe that certain witnesses ought to be interviewed by the investigator, it is important to provide as much information as possible as to why those witnesses are important. The investigator is not obliged to interview each and every witness you identify

unless the investigation would not be thorough without hearing from those witnesses.

(3) During the investigation, you will likely be provided with a summary of the respondent's position. In many cases, the respondent refers to information which you are not aware of or which you may wish to respond to in any event. As with the intake stage, as much information as possible should be provided to respond to the respondent's position. Do not hesitate to ask the investigator to obtain further information in the event it is necessary to properly reply to the respondent's position.

(c) **Disclosure and Submissions**

(1) As indicated above, when the investigator completes the investigation report, the parties are entitled to make submissions on it.

(2) In many cases, complainants simply provide a brief written comment regarding the findings of the report without submitting additional documentation. The Commissioners may not, however, have access to that additional documentation. As a result, it is imperative that you ensure that all of the important documents respecting your complaint are placed before the Commission with your submissions on the investigation report.

(3) It is obviously important to provide specific submissions and evidence where the investigator recommends the dismissal of your complaint or otherwise makes findings against you. However, even where the investigator finds in your favour, it is important to provide all of the information and evidence necessary to support the basis for your complaint. This is because the Commissioners are not bound by the recommendation and may be influenced by the Respondent's submissions.

(4) Keep in mind that the respondent will also make submissions on the report which may very well convince the Commission to dismiss your complaint. A positive report therefore should not go without comment. Rather, the evidence which supports your complaint should be summarized in a submission and filed with the Commission so that it has all of the information it needs to make a decision.

(5) Providing this information at this stage is also important in the event that a judicial review application is subsequently initiated in the Federal Court to set aside the decision. Generally speaking, the Commission cannot be criticized in a judicial review application for failing to consider evidence that you had not given to it. Accordingly, providing as much

evidence as possible is necessary to protect yourself in the event you wish to take the matter to the Federal Court. In certain circumstances, however, evidence which was not before the Commission may be tendered to the Federal Court where, for example, it is alleged that the Commission breached the rules of procedural fairness.

(6) As noted above, if the opposing party raises new matters in their submission, you will be provided with a copy for your comment. As with the submissions on the investigation report, you should always take advantage of this opportunity as this is your last chance to provide information to the Commission which contradicts the respondent's position.

V. Points to be Made in your Submissions

(1) You should emphasize in your submissions the facts which support your complaint as well as the evidence which supports those facts. If you know the Respondent's position, you should present any facts or evidence to respond to it.

(2) The Commission is required ultimately to act in the public interest. Where a case raises important issues of discrimination, particularly where the issues are matters of principle which might impact upon others, the Commission may be more interested in referring the matter to a tribunal for an inquiry. If possible, therefore, your submissions should emphasize the broad impact of your complaint.

(3) Do not forget to address any legal issues which are raised by your complaint. In some cases, this may require legal research and references to legal precedents which support your position.

(4) When the Commission invites submissions on the report or any other materials filed by the opposing party, it usually specifies that your submissions can be up to ten pages in length. While this is an administrative guideline, the Courts are not likely to view it as being binding. If you require more than ten pages to address the issues raised by the report or the respondent's position, then you should do so.

(5) Having said that, at all times you should try to be as concise and focussed as possible. Your actual written submission will usually not exceed ten pages. However, it may be the case that all of the documentary evidence will exceed that page limit.

VI Judicial Review

If the Commission renders a decision with respect to your complaint that you disagree with, judicial review in the Federal Court is an option. Judicial review applications should be commenced within thirty days of the date you are informed of the Commission decision. The Federal Court’s authority is limited by the grounds set out in the *Federal Court Act* and the case law which has developed regarding the authority of the Commission to investigate and consider human rights complaints. You may wish to seek legal advice regarding the process before the Federal Court.

Chapter 11

Public Service Staff Relations Act
Adjudicability of Human Rights Grievances

Introduction to Chapters 9,10 and 11

These chapters contain background information and concrete advice on the actions you can take if your employment is terminated because you have a disability.

Included are:

An introductory letter from PSAC National President Nycole Turmel

Chapter 9: Information on grievances and grievance wording you can submit

Chapter 10: Information that you need to know if you should also wish to file a human rights complaint.

Chapter 11: Information on the relationship between your right to grieve and your rights under the Canadian Human Rights Act, and
http://www.psac.com/what/representation/27-e.shtml

or

See pages 77 to 82

The adjudicability of human rights grievances for employees covered by the Public Service Staff Relations Act

The adjudicability of human rights grievances for employees covered by the Public Service Staff Relations Act

In 2000, the Supreme Court of Canada denied the Public Service Alliance of Canada's application for leave to appeal in the *Mohammed** case. This meant that the Federal Court of Appeal decision in that case was the law and that the filing and adjudication of grievances dealing in whole or in part with human rights was not allowed. It was a profound disappointment to this union that the Supreme Court's decision effectively barred individual members from having direct access to the grievance and adjudication procedure on human rights matters. Unionized employees under the *PSSRA* are the only unionized employees in Canada unable to directly use the grievance procedure on human rights issues. The PSAC regards this as unacceptable and we are pressing for legislative changes.

However, at the time that the Supreme Court of Canada denied our appeal, a number of issues were still unclear and awaiting future developments.

The PSAC now wishes to advise its members that the basic framework re human rights matters is now settled and should remain the same until the *PSSRA* is changed to allow direct access to the grievance and adjudication procedure. The essence is that, while **direct** filing and processing of human rights grievances is still not possible, there is now **indirect** access to the grievance and adjudication procedure if (but only if) the Canadian Human Rights Commission has issued a s. 41 order with regard to a CHRC complaint by the same member on the same issue. The CHRC acts, in essence, as a gatekeeper, sending some matters to the grievance/adjudication procedure and keeping others for CHRC processing. Please note that there is no possible access to the *PSSRA* grievance/adjudication procedure without first having filed a CHRC complaint and receiving a s. 41(1) direction from the CHRC. The terms "bounce-back" or ‘kick-back" are the informal terms being used to describe cases that the CHRC has decided should be re-routed to the grievance/adjudication procedure. The other significant development is that, contrary to the earlier situation, s. 99 references are no longer

available as a means for bringing individual human rights issues to the PSSRB.

Note that the *Mohammed* case is now officially cited as *Boutilier*, [2000] 3 F.C. 27 (FCA). *Boutilier* and *Mohammed* were heard together and covered by the same decision.

The following is a summary of the present, settled situation.

1) Grievances related to human rights may not be filed directly with employer (*Boutilier/Mohammed* barrier)

The courts have now concluded that employees governed by the *Public Service Staff Relations Act (PSSRA*) no longer have the right to direct use of the grievance procedure in any matter related to human rights. The key decision is the Federal Court of Appeal's December 2, 1999 decision in *Boutilier*,[2000] 3 F.C. 27, also known as *Mohammed*.

The basis for the FCA's denial of direct use of the grievance procedure on human rights matters is that s. 91(1) of the *PSSRA* stipulates that the right to file grievances is limited to matters for which Parliament has not provided another "administrative procedure for redress". *Boutilier* held that Parliament had established another "administrative procedure for redress" re human rights, i.e., the complaint procedure under the *Canadian Human Rights Act (CHRA)*, therefore there is no direct right to file human rights grievances under the *PSSRA*.

2) CHRC s. 41(1) (a) or (b) order prerequisite for filing a human rights-related grievance

The FCA in *Boutilier* also held that Parliament intended for the Canadian Human Rights Commission (CHRC) to act, in effect, as a gatekeeper or screening house in dealing with human rights matters for *PSSRA* employees. The Court stated that, in handling a complaint:

"the CHRC may, if it chooses, send the matter to grievance pursuant to subsection 41(1) of the *CHRA*" (see para. 18 of *Boutilier*).

As a result, the *PSSRA* grievance procedure becomes valid and available **only if** the CHRC invokes s. 41(1) of the *CHRA* to direct that the complainant use the grievance procedure.

The Court in *Boutilier* recognized the difficulties in this procedure when it stated:

"In my view, Parliament has enacted a particular method of resolving these questions, a rather complex, costly and time-consuming method perhaps, but until Parliament can be convinced to change its legislation, this Court will honour that legislative choice…."

3) <u>Factors to be considered by CHRC re a s. 41(1) "bounce-back" to grievance procedure</u>

The CHRC's manual on the complaint process describes the factors to be considered in deciding whether to direct a complainant to use the grievance process. This decision is made at the intake step, with a recommendation made by an officer and the final decision by the Commission itself. The factors to be considered include:

- whether the issue is one requiring immediate attention by the CHRC;

- whether the grievance process has the mandate [i.e., jurisdiction] to deal with the issue;

- whether all the necessary remedies are available (Note that *PSSRA* adjudicators do not have the power to award damages for pain & suffering, nor to order appointments, including promotions, but Human Rights Tribunals do have those remedial powers); and

- the wishes of the complainant re whether to use the grievance procedure (Note: the CHRC will grant considerable weight to the complainant's wishes, but is not required to follow them).

(Note: while the present CHRC manual does not clearly instruct Commission officers to consult with the union before recommending a s. 41(1) bounce-back, the Commission regards that as implicitly required and has undertaken to amend the manual to make this clear. Union consultation is important because: 1) union approval & representation is required before any collective agreement grievance may proceed; and 2) the union has knowledge of *PSSRA* jurisdiction and remedy matters that the CHRC officer may not have.)

4) <u>Possible return to CHRC after grievance/adjudication procedure finished</u>

Once the grievance/adjudication procedure following a s. 41(1) order is ended, the complainant may ask the CHRC to re-open the complaint file and the CHRC must then seriously consider that request and decide whether it will do so. This second-look by the CHRC reflects court decisions that *require* the Commission to look at the specifics of the situation and make up its mind whether further CHRC proceedings are warranted. In making its decision, the CHRC will consider:

- whether the remedy obtained in the grievance/adjudication process is sufficient;

- whether any human rights issues remain outstanding; and

- the parties' submissions re why the Commission should or should not proceed

5) <u>Treasury Board's instructions re human rights grievances, CHRC complaints & complaints under Treasury Board harassment policy</u>

The PSAC met with representatives from the CHRC and Treasury Board in order to discuss the change in the jurisprudence and discuss how each of the parties would apply this change. Treasury Board informed us that with respect to attempts to file grievances on *CHRA* human rights grounds, departments would be instructed to tell the employee to "file a complaint with the CHRC [and] ... to put the employee's grievance in abeyance in case CHRC kicks it back". Treasury Board is within its rights to place such grievances in abeyance because, as described above, there is no right to file a human rights grievance until the CHRC issues a s. 41(1) order. The PSAC understands that TB is encouraging departments to attempt informal problem solving while the grievance is in abeyance pending the CHRC's decision on the s.41(1) bounce-back issue. We support them in this approach.

6) <u>When to file human rights grievances and when time limits begin to run</u>

Members may wish to attempt to file a human rights grievance before or at the same time as filing a CHRC complaint, but there is no legal need to do so. As indicated, TB is instructing departments to hold such grievances in abeyance pending the CHRC's bounce-back decision. Even though such a grievance will not be officially processed by the employer unless a s.41(1)

direction is issued, it may be useful to file a grievance before or at the same time as filing a CHRC complaint in order to have access to informal problem solving with the employer while the grievance is in abeyance.

Legally, the time limits for filing a human rights grievance only begin to run once the complainant is notified by the CHRC of a s. 41(1) bounce-back order. Time limits for grievances do not run prior to a s.41(1) order because there is no legal right to grieve until the s. 41(1) direction is issued. Once a s. 41(1) direction is issued by the CHRC, complainants should be certain to activate the grievance process within the time limits established by the collective agreement. This applies whether the complainant has already filed a grievance that is being held in abeyance or will be filing a grievance only after the s.41(1) direction is issued.

7) *Djan* case and temporary uncertainty whether s.41(1) bounce-back procedure valid

Djan (166-2-29395) was the first case after the FCA decision in *Boutilier* in which the PSSRB attempted to deal with a grievance that went to adjudication as the result of a CHRC s. 41(1) order. Treasury Board immediately objected to the PSSRB's jurisdiction to hear this grievance by a PSAC member, despite the fact that the Federal Court of Appeal in *Boutilier* (cited above) had very clearly held that a s.41(1) direction by the CHRC would legitimize use of the PSSRA grievance/adjudication procedure. In a decision released June 11, 2001, the PSSRB agreed that it did, in fact, have jurisdiction. Treasury Board decided not to appeal that decision to the Federal Court and the s. 41 (1) jurisdiction issue appears to be settled.

8) Section 99 references no longer possible

Previously, the PSAC had contemplated using s. 99 references under the *PSSRA* as a means to bring members' human rights issues before the PSSRB. The provisions of s. 99 restrict its use to issues that are not enforceable by individual grievances. After *Djan*, it is clear that individual grievances re human rights matters are now possible, provided, of course, that the CHRC has issued a s.41(1) direction validating the grievance procedure in a particular case. In light of that, the s. 99 reference is no longer a plausible option.

Format for Letter requesting the Canadian Human Rights Commission exercise the Bounce Back provisions.

Re.: (NAME), CHRC File No(s).:

I request that the Commission exercise its discretion pursuant to s. 41(1)(a) of the Canadian Human Rights Act (CHRA) and refer this matter to the Public Service Staff Relations Board (PSSRB) and allow me, pursuant to the Public Service Staff Relations Act (PSSRA), to seek redress by means of the grievance/adjudication procedure. As a member of Local **(Identity)** of the (NAME) Component of the Public Service Alliance of Canada (PSAC), I have access to the grievance system leading to third-party review by an Adjudicator of the PSSRB. I have filed a grievance and a copy is attached for your information. I understand that should this matter pain and suffering will not be available. However, I believe the Board would have the jurisdiction to deal with all other matters arising from this Complaint. I realise the Commission will consult with the Coordinator of the PSAC Representation Section (Telephone: 613-560-4325, Fax: 613-236-0062) to confirm union approval of representation befor the PSSRB prior to any final decision on referral of this Complaint.

Yours truly,

(SIGNATURE)

(NAME)

cc. Component President, (w/attch.)
PSAC Representative, (w/attch.)
Coordinator, PSAC Representation Section, (w/attch.)
Legal Services, PSAC Membership Programs Branch, (w/attch.)

Chapter 12

Duty to Accommodate

Introduction to Chapter 12

Chapter 12 contains the PSAC guide "The Duty to Accommodate". This guide for local representatives clearly explains the obligations around the Duty to Accommodate.

The evolution of human rights legislation has been encouraging. Recent court interpretations of the Duty to Accommodate place a positive obligation on employers to design workplace standards and requirements so that they do not discriminate. Employers must build conceptions of equality into workplace standards. Employers who ignore their obligations and terminate members who have disabilities are probably violating this important human rights obligation.

It is extremely difficult however to make a balanced assessment of what actions to first engage in on behalf of the member.

On one hand when the union is representing a member who is on disability insurance, it is a mistake to compromise to quickly, especially when there are tools available that can force the employer to accommodate. We must help members exercise their rights. On the other hand, Human Rights cases can take a long time. Sometimes our members on DI need immediate financial assistance. It isn't helpful to build false hope with a member or to pressure someone to go back to work when they are not well enough. Every case varies and must be seen according to its own facts.

The Duty to Accommodate is powerful right of which the member can take advantage. Discussing it will help members understand the whole breadth of options that they have available to them.

http://www.psac-afpc.org/documents/what/duty_to_accommodate-e.pdf

Chapter 13

HRDC Employment Insurance Sickness Benefits Guide

Introduction

Members may qualify for Employment Insurance (EI) sickness benefits during their elimination period while they are on Leave without pay and waiting for their disability insurance to begin. Members may have enough sick leave. They may not however and may need to depend on EI, or a combination of EI and their earned sick leave.

The following document produced by HRDC answers some questions about EI sickness benefits.

See pages 85 to 90

Employment Insurance Sickness Benefits
Human Resources Development Canada

Section I

Q. What does this mean to you?
A. You will need only 600 insured hours of work instead of 700 to be eligible for sickness benefits. This means that more Canadians will be able to benefit.

Q. Where do I apply?
A. At any Human Resources Development Canada Office

Q. When will you receive your first payment?
A. If we have all the required information and if you qualify for benefits, your payment will be issued usually **within 28 days** of the start date of your claim. If you do not qualify, we will notify you of the reasons within that time frame.

Q. How much should I receive?
A. The basic benefit rate is 55% of your **average insured earnings** up to **a maximum amount of $413 per week**. Your EI payment is a taxable income, meaning provincial (if it applies) and federal taxes will be deducted. You could receive a higher benefit rate if you are in a low-income family (an income of less than $25,921) with children and you or your spouse receive you are entitled to the Family Supplement.

Q. How long can I collect sickness benefits?
A. Sickness benefits may be paid up to **15 weeks** to a person who is unable to work because of sickness, injury or quarantine.

Section II

Who is eligible?

Sickness benefits - People whose illness, injury or quarantine prevents them from working

You are entitled to Employment Insurance (EI) benefits provided you meet these requirements:

- you must apply
- you must have paid into the EI account: and
- You have worked the required number of hours.

Sickness benefits explained

Sickness benefits may be paid up to 15 weeks to a person who is unable to work because of sickness, injury or quarantine.

If you are already on a claim for reasons other than illness and while you are on a claim you fall ill, then you may qualify with less than 600 hours. Check with your local HRDC office if this is the case.

As well, you can receive sickness benefits in addition to maternity or parental benefits, but you cannot receive more than 50 weeks of combined maternity, parental and sickness benefits in one benefit period.

To receive sickness benefits you are required to have worked for 600 hours in the last 52 weeks or since your last claim. A medical certificate telling us how long the illness is expected to last must be provided. Please note that the fees requested by your doctor are entirely at your own expense. If you work while on sickness benefits, your earnings will be deducted dollar for dollar from your benefits.

A person who makes a claim for sickness benefits is not only required to prove to be unable to work but also that he or she would be otherwise available for work.

While you should apply for benefits as soon as you stop work or become unable to work, sometimes people are too ill to apply right away. If this is the case for you, tell us about it and we may be able to back date your claim to the time your earnings stopped.

Section III

How much will you receive?

The basic benefit rate is 55% of your average insured earnings up to a maximum amount of $413 per week. Your EI payment is a taxable income, meaning provincial (if it applies) and federal taxes will be deducted.

You could receive a higher benefit rate if you are in a low-income family (an income of less than $25,921) with children and you or your spouse receive the Canada Child Tax Benefit (CCTB), you are entitled to the Family Supplement.

You do not have to apply for the family supplement. If you are eligible to receive it, your entitlement will automatically be added to your EI cheque.

How we calculate the amount you will receive?

The amount of your weekly benefit payment depends on your earnings in the last 26 weeks and is calculated in the following manner:

1. We look at the total earnings you have been paid in the last 26 weeks ending with your last day of work.

2. We take into consideration the number of weeks in which you have worked in the last 26 weeks.

3 We determine the unemployment rate in your region and the minimum divisor that applies at that unemployment rate.

4. We determine your average weekly insured earnings, by dividing your total earnings in the last 26 weeks by the greater of:

   a. the number of weeks you have worked in the last 26 weeks; or
   b. the minimum divisor number

5. We then multiply the result by 55% to obtain your weekly benefit. The maximum amount is $413 per week. (See examples A and B)

Example A

1. In the last 26 weeks you worked for 26 weeks and earned a total of $10,400.

2. You live in an area where the unemployment rate is 13.1%; so the divisor is 14

3. To determine your average weekly earnings: We calculate $10,400 ¸26 = $400. (We use the number of weeks worked as it is greater than the divisor)

4. To determine your weekly benefit rate: We calculate 55% of $400 = $220 per week in benefits.

Example B

1. In the last 26 weeks you worked for 12 weeks and earned a total of $3,600.

2. You live in an area where the unemployment rate is 13.1%; so the divisor is 14.

3. To determine your average weekly earnings, your total earnings ($3,600) will be divided by 14 (the minimum divisor) as it is greater than the number of weeks worked (3,600 divided by 14 = $257);

4. (If your basic benefit rate is 55%, then you could receive $141 per week in benefits (55% of $257) 55% of $257 = $141

When do benefits start?

- **If you reopen a claim** for benefits in which you have already served the two week waiting period then you do not serve the waiting period again.

- **If you receive group insurance payments**, you can serve the 2-week waiting period during the last two weeks that these payments are being paid.

- **If you get paid leave for sick time,** you may not have to serve a waiting period at the end of your paid leave before your EI benefits can start.

If you have provided us with all the information and documents we require and if you qualify for benefits, you should receive your first cheque by the end of the fourth week (28 days) after applying for benefits.

We will send you a notice with your last cheque saying that you have received all the sickness benefits to which you are entitled. If you don't have a job to go back to, you may be able to receive regular EI benefits without a waiting period. Please see the booklet, *Employment Insurance: Regular benefits*, available at any Employment Insurance office, for more information.

Sources of income

If you work while on **sickness benefits**, your earnings will be deducted dollar for dollar from your sickness benefits.

- any income including wages or commissions from employment

- any payments in compensation for an accident or work related illness, such as workers compensation for lost wages.

- income from group insurance for sickness or loss of income

- some accident compensation for loss of wages

- retirement income from an employment pension, military or police, Canada or Quebec Pension Plan or provincial plan based on employment.

Section IV

Repayment of benefits at income tax time

For more information, please see our fact sheet **Employment Insurance: Repayment of benefits at income tax time** or visit any Employment Insurance office.

Note to reader

Changes to the repayment of benefits were proposed by the Government in the House of Commons on September 28, 2000. The proposed changes have not, at this time, been adopted by Parliament, consequently the above information is still applicable.