EDMONTON

Supplementary Income Replacement Plan (SIR)

The City of Edmonton has determined that it wishes to pay Employment Insurance premiums at a reduced rate by providing a Supplementary Income Replacement (SIR) Plan for all temporary, provisional and non-permanent part-time employees.

The SIR Plan applies to temporary, provisional and non-permanent part-time employees, as these terms are defined under the respective collective agreements.

The attached appendices set out the obligations, rights and benefits accruing under the SIR Plan for temporary, provisional and non-permanent part-time employees of the City of Edmonton.

Definitions

Disability

Means the Member is unable to perform a substantial portion of their regular duties because of sickness or injury.

Member

Means an employee who occupies a position that is classified as temporary, provisional or non-permanent part-time pursuant to the collective agreement governing that position.

Plan

Means the SIR Plan provided for and continued herein or in any properly amended form.

Attachments

Appendix I – SIR Plan
Appendix II –SIR Claim Form

Effective Date of Coverage

- Members are eligible to participate in the Plan upon completing 90 calendar days of continuous civic employment since the last date the member commenced employment with the City.

Elimination Period

- Benefits commence on the Member's 10th consecutive calendar day of absence due to illness or injury.

Eligibility for Benefits

- Members must provide a completed SIR Claim Form to the City's Disability Management Services area within the Employee Safety and Wellness Section that provides objective and clinical medical information to substantiate that they are unable to perform a substantial portion of their regular duties because of disability.
- The SIR Claim Form must be submitted bi-weekly until the Member is determined to be fit for work or the Member's entitlement to SIR benefits is exhausted.
- SIR benefits will not be paid where the SIR Claim Form is not signed by both the Member and the physician.

Benefit Amount

- The Member will receive 55% of their "regular bi-weekly insurable earnings" up to a maximum of $826 bi-weekly for their period of absence to a maximum of 80 working days. For Members whose scheduled hours of work vary each pay period, the benefit payable will be equal to 55% of their "average regular bi-weekly insurable earnings". For the purposes of this provision, "average insurable earnings" has the meaning assigned to it under the *Employment Insurance Act*.
- The maximum benefit amount will be automatically increased to match any future increases in the Employment Insurance maximum insurable earnings.
- Benefit payments are taxable.

Benefit Duration

- Benefits cease at the earliest date the Member:
  - is no longer disabled;
  - has received 75 working days of benefits;
  - retires; or
  - is no longer employed by the City for any reason other than illness or injury if the notice of lay-off or termination is given prior to the onset of disability.

Recurrent Disability/Reinstatement of Benefits

- A Member who returns to work following the end of an illness or injury is again entitled to 75 working days of benefits:

  (i) in the case of a new disability, upon completion of one (1) month of "continuous employment"; or

  (ii) if the disability is a recurrence of an earlier period of disability, upon completion of three (3) months of "continuous employment".

  For the purposes of this provision, "continuous employment" means the Member's normally scheduled hours of work.

Limitations and Exclusions

- Members are not eligible for SIR benefits for any days or portions thereof for absence other than their regularly scheduled hours of work.
- No SIR benefits are payable if the Member is not under the on-going care of a licensed physician.
- No benefits are payable during the period a Member is on a leave of absence, including maternity leave, or on paid vacation.
- Members are not eligible for SIR benefits if they are not entitled to income benefits payable by Employment Insurance by reason of being outside of Canada.
- Benefits will terminate immediately, if the Member engages in employment for wage or profit while in receipt of SIR benefits.
- Benefits will not be payable for any disability:
    - due to or resulting from any cause for which indemnity or compensation is provided under Workers' Compensation or the Canada Pension Plan (excluding those disability benefits payable on behalf of the Member's dependents);
    - due to or resulting from self-inflicted illness or injury, while sane or insane;
    - resulting from war, participation in a riot or disorderly conduct;
    - resulting from service in the armed forces;
    - that occurs while the Member is on a leave of absence, on paid vacation or which occurs during a strike or lockout; (The Member's entitlement to benefits under this Plan will be reinstated upon return to active employment.)
    - where the Member is not receiving continuous treatment for the use of drugs or alcohol when the disability results from the Member's use of these substances;
    - if the Member is in receipt of maternity or parental benefits under the *Employment Insurance Act*;
    - resulting from plastic surgery solely for cosmetic purposes except where attributable to illness or injury;
    - any period the member is imprisoned.
- While in receipt of SIR benefits, the Member must be available (at all times) to perform any reasonable obligations required by the City's Disability Management Consultant to substantiate and/or justify their claim for SIR benefits.
- A Member who is absent from work due to a disability may be required to provide a medical certificate signed by a licensed physician that states the Member is medically fit to return to the duties of their position.

SUPPLEMENTARY INCOME REPLACEMENT CLAIM FORM

Please return the completed form to Disability Management Services, Human Resources Branch, City of Edmonton, 9th Floor, 9803 – 102A Avenue, Edmonton, Alberta, T5J 3A3 or by FAX: 496-9227

Employee Name: _____ Department No: _____

Position/Title: _____ Payroll No: _____

Home Phone No.: _____ Work Phone No.: _____

Address: _____ Postal Code: _____

First Day/Shift Absent: _____

All personal information is collected under the authority of section 33(c) of the *Freedom of Information and Protection of Privacy Act*. It will be used in the administration of Human Resources policies and programs, including eligibility for disability benefits and development of return to work plans. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the Team Lead, Disability Management Services, 9th floor, Century Place, (780) 496-5951.

Important Information

If the medical information I have provided is deemed inadequate by the City of Edmonton, I understand that the City may contact me to obtain additional information. Alternatively, by placing my initial in this space _____ I hereby authorize the City to contact my physician, Dr. _____ to provide additional information about my functional capabilities, as it may be required for adjudicating and managing my claim and assessing return to work opportunities. I understand that prior to contacting my physician, the City of Edmonton will make reasonable attempts to contact me by telephone to advise me of their intention to speak with my physician.
I understand that it is my responsibility to gather and forward required medical information in a timely manner or risk stopping of payments of my claim and possible non-payment of the claim. Furthermore, I understand that if disability benefits have already been received and I fail to provide sufficient medical information to substantiate the claim, all or some of the funds may be recovered from me.
I hereby assign and subrogate to the City of Edmonton all my rights to claim for, prosecute, and receive any money from any person with respect to my lost earnings, hospital expenses, or medication or other medical costs which the City of Edmonton has or will have paid to me under any of its benefit plans, and I further authorize the City of Edmonton to deduct the amount of such money or compensation recovered by me from my wages, overtime pay or other compensation that the City of Edmonton does or shall hereafter owe to me. Where any clause in this form is inconsistent with any applicable collective agreement provisions, the collective agreement governs. I hereby agree to cooperate fully with the City of Edmonton in providing to it such information as it may require to recover any money or compensation paid to me as above.
Understanding that it is a serious offence, punishable by discipline and/or dismissal to falsify any information on this form, I hereby certify that the statements made by me are true and correct.

Date:		Employee's Signature:	

Third Party Claims: Was the disability caused through third party injury?	Yes ☐ No ☐
If yes, specify date of incident:	Lawyer's name and contact number:

All City of Edmonton employees wishing to leave the greater Edmonton area while absent from work due to illness/injury must obtain prior approval from their Disability Management Consultant. Without prior approval the employee may not be entitled to receive benefits during the whole period he/she remains outside the greater Edmonton area.

Employees may be reimbursed up to $30.00 for costs associated with completion of this form, subject to all required medical information on following page being provided. Submit original receipts with this form.

Please have the reverse side of this form completed by a licensed physician.

Appendix II

IMPORTANT NOTICE TO PHYSICIAN

The City of Edmonton has implemented a modified/alternate work program to assist our workers recovering from illness/injury with early intervention to modified or alternate duties. Please ensure information is sufficiently detailed, as it will be used to assist in adjudication and the development of return to employment plans. Information provided on this form is confidential.

To Be Completed by a Physician:

Patient Name:	
Date of 1st Visit for current illness/injury:	Is it work related?:

Nature of current illness/injury:

_____
_____
_____

If applicable, please indicate: DSM-IV_____ and GAF score_____

Current treatment plan:

_____
_____
_____

Please indicate the patient's functional capabilities:

Activity	Unable to Perform	Partial Limitation	No Limitation	**Activity**	Unable to Perform	Partial Limitation	No Limitation
Sitting				Driving			
Standing				Walking			
Crouching				Kneeling			
Crawling				Balancing			
Finger Dexterity				Reaching Overhead			
Pulling				Pushing			
Bending				Grasping			
Carrying				Lifting			
Repetitive use-Foot				Repetitive use-Hand			
Vision				Hearing			
Environmental sensitivities (heat, noise, moisture, etc.):							
Other specific restrictions (eg. Cognitive):							

To the Best of My Knowledge this Patient has been unable to work from _____ to _____.

Indicate Approximate Date Patient should be able to return to work: _____

Physician's Name:	Specialty:
Telephone Number:	Date: