Teck Coal Limited
Elkview Operations
R.R. #1, Highway #3
Sparwood, B.C. Canada V0B 2G0

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Memorandum

To: Elkview Employee **Date:** April 7, 2020

From: Maryanne Lockwood

Subject: Short Term Disability Claim

The qualifying period for your Weekly Income Benefits is as follows:

-Accident – 0 Days

-Sickness – 2 calendar days for 12 and 10 hour shift employees, 3 calendar days for 8 hour shift employees.

-If hospitalization occurs prior to the end of the qualifying period, benefits are payable as of that date.

The enclosed Short Term Disability claim form consists of the following:

Medical Absence Form – to be completed by your physician at (1) the onset of your absence and (2) prior to your return to work. The completed form is to be faxed to the EVO HR confidential fax # at 250-425-8727.

Plan Member Statement - to be completed by the employee. Your "Member ID" is your employee number. The Plan Contract Number is 100258. If you would like your payments to be direct deposited into a chequing account, you must provide a copy of a void cheque.

Attending Physician's Statement – employee must sign the Member Authorization at the top of the form. The remainder of the form is to be completed and signed by your physician.

Once complete, it is your responsibility to email or fax the Plan Member Statement and Attending Physician's Statement to Sun Life's Vancouver office at:

disabilityclaims@sunlife.com or

Fax to 1-866-639-7829. Ensure forms are complete, signed and dated. Incomplete or unsigned paperwork may result in a delay in processing your claim.

Once the Plan Member and Attending Physician forms have been faxed to Sun Life please call me at 250-425-8775, I will then forward the Employer's Statement to Sun Life which is required to complete the claim. **This will ensure there is no delay in the processing of your claim.**

If you have any questions regarding the completion of your Short Term Disability Claim please call.

Returning to Work

Medical Absence Form – As noted above please have completed form faxed in prior to return to work.

Plan Member's Statement
Claim for Disability benefits

Sun Life Financial

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

1 Plan Member information

In order to avoid any delays in the assessment of your Short-Term Disability (STD) and where applicable, Long-Term Disability (LTD) claim, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If disability benefits under your Short-Term Disability or if applicable, Long-Term Disability Plan are taxable, your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite
City		Province	Postal code
Occupation	Job title	Social Insurance Number	
Home telephone number	Alternate telephone number		
What province were you living in at the time your coverage became effective under this plan?	Preferred language of correspondence ☐ English ☐ French		

If you would like Sun Life Assurance Company of Canada ("Sun Life") to email you, please fill in your email address below. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

Email address

2 Plan Sponsor information

Contract number	Member ID	Company name	
Contact person	Contact person email	Contact person phone number	

3 About your illness or injury

You must notify Sun Life if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

1. Please describe your present illness or injury and how it occurred.

3 About your illness or injury (continued)

2. When did your symptoms first appear? Date (dd-mm-yyyy)
3. Have you ever had the same or similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

4. Is your condition related to pregnancy? ☐ No ☐ Yes If yes, what is your delivery date? Date (dd-mm-yyyy)
   Please describe your complications, if any.

5. From what date did your illness or injury prevent you from working? Date (dd-mm-yyyy)
6. Please include a list of the duties of your job that you are unable to do.

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

8. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

3 About your illness or injury (continued)

9. When do you expect to be able to return to work? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

10. Have you tried to return to work already? ☐ No ☐ Yes If yes, please answer the following questions.

What were the dates that you returned to work? From Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

Did you return to: ☐ your own job ☐ new job or modified duties

Did you return to: ☐ full-time ☐ part-time

4 Disability as a result of an accident

1. Is your disability the result of an accident?

☐ No If no, continue with the next section "**Your other income**".

☐ Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location

2. Were you working for your employer at the time of the accident? ☐ No ☐ Yes Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident? ☐ No ☐ Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number

3. If your disability is the result of an accident, are you taking legal action against any other person or organization?

☐ No If no, explain why you are not taking legal action.

☐ Yes If yes, please complete the following:

Name of lawyer			Telephone number
Address	City	Province	Postal code

On what date did the legal action start? Date (dd-mm-yyyy)

Has a settlement been reached? ☐ No ☐ Yes If yes, please attach a copy of the terms of the settlement.

5 Your other income

Please list any amounts of money you are currently receiving or expect to receive each week or month from the following sources. We may take some of these amounts into consideration when we calculate your Short-Term Disability benefit.

Source	Insurance Co. & Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per ☐ Week ☐ Month	When are your benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. WCB/WSIB/ CNESST, Union Disability Benefit, Creditor, Credit Cards, etc.)		☐	☐	☐	☐	$	
Auto Insurance		☐	☐	☐	☐	$	
Other Group/Association/Individual Plans		☐	☐	☐	☐	$	
Employment Insurance		☐	☐	☐	☐	$	
Quebec Parental Insurance Plan		☐	☐	☐	☐	$	
Canada/Quebec Pension Plan		☐	☐	☐	☐	$	
Employer Disability, Severance or Retirement		☐	☐	☐	☐	$	
Any other Accident/Group/Association/ Government Disability Benefit		☐	☐	☐	☐	$	
Other (specify) i.e. in Quebec, Criminal Victims Benefits		☐	☐	☐	☐	$	

6 Automatic deposit of your disability payments

This service is subject to the approval of your claim.

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque. Please check with your Benefit Administrator to determine if this option is available to you.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

7 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan and we will verify the accuracy of the information given in support of your claim.

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

I certify that the statements in this form are true and complete.

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my claim. I authorize Sun Life and its reinsurers to collect, use and disclose information needed for underwriting, administration, adjudicating claims under the STD Plan and, where applicable the LTD plan to any person or organization who has relevant information pertaining to my claim including health professionals, institutions, investigative agencies, insurers and, where applicable, my Plan Sponsor. I agree that Sun Life and my Plan Sponsor may also share financial information related to my claim for purposes relevant to the management of both Plans. I understand that information about me pertaining to my claim may be reviewed in the event these Plans are audited.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the STD plan, and where applicable the LTD plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

Member's last name (please print)	First name

Member's signature	Date (dd-mm-yyyy)
X	

8 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.

If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.

You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to *disabilityclaims@sunlife.com*. Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:
Fax: 1-866-639-7850
PO Box 11480 Stn CV
Montreal QC H3C 5P5

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

Edmonton:
Fax: 1-866-639-7820
PO Box 2733 Stn Main
Edmonton AB T5J 5C9

Toronto:
Fax: 1-866-639-7851
PO Box 950 Stn A
Toronto ON M5W 1G5

Vancouver:
Fax: 1-866-639-7829
PO Box 48810 Stn Bentall
Vancouver BC V7X 1A6

9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Attending Physician's Statement Disability Claim

Sun Life Financial

Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada ("Sun Life") in making a decision on your patient's claim for disability benefits.

The term "claim" as used throughout this statement relates to the assessment of the plan member's absence from work under the Short-Term Disability (STD) plan and where applicable, the member's absence from work under the Long-Term Disability (LTD) plan.

Return address

Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

Edmonton:	Toronto:	Halifax:	Montreal:	Kitchener - Waterloo:	Vancouver:
Fax: 1-866-639-7820	Fax: 1-866-639-7851	Fax: 1-866-639-7850	Fax: 1-866-639-7846	Fax: 1-866-209-7215	Fax: 1-866-639-7829
PO Box 2733 Stn Main	PO Box 950 Stn A	PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Montreal QC H3C 5P5	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6

1 Plan Member information and authorization to be completed by patient

Last name	First name	Home telephone number	Alternate telephone number

Address (street number and name)	Apartment or suite

City	Province	Postal code

Plan Sponsor name	Contract number	Member ID number

Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature	Date (dd-mm-yyyy)
X	

2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Section 2 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete all sections in full.

Diagnosis

Primary:

Secondary:

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

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

Start dates of current work absence

Date of first visit during current period of absence (dd-mm-yyyy)

First date of work absence due to condition (dd-mm-yyyy)

2 Attending Physician's Statement (continued)

Hospitalization

Has your patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy)

Have they had day surgery? ☐ Yes ☐ No Date discharged (dd-mm-yyyy)

Name of institution:

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy)	Description	Type of anaesthetic

Treatment (Drug, dosage, physiotherapy, other)

Prognosis – Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy)

Visits – Frequency of visits ☐ Weekly ☐ Monthly ☐ Other

Symptoms – Describe current symptoms, severity and frequency.

Investigations – **Please attach copies of all relevant:**

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Please note that Genetic testing information is not required , so please do not include.

Are tests/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy)

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist	Specialty	Date of visit (dd-mm-yyyy)

Restrictions and limitations – Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

<table>
<tr><td>Last name of attending physician (please print)</td><td>First name</td><td colspan="2">Certified specialist</td><td rowspan="4">Physician's stamp</td></tr>
<tr><td colspan="4">Address (street number and name)</td></tr>
<tr><td colspan="2">City</td><td>Province</td><td>Postal code</td></tr>
<tr><td colspan="2">Telephone number</td><td colspan="2">Fax number</td></tr>
<tr><td colspan="4">Physician's signature
X</td><td>Date signed (dd-mm-yyyy)</td></tr>
<tr><td colspan="5">NOTE: Your patient is responsible for any charge made for the completion of this form.</td></tr>
</table>

Teck

MEDICAL ABSENCE FORM

STRICTLY CONFIDENTIAL

☐	**COAL MOUNTAIN OPERATIONS**	BOX 3000, SPARWOOD, BC V0B 2G0	**FAX: (250) 425-7371**
☐	**ELKVIEW OPERATIONS**	RR1, HWY 3, SPARWOOD, BC V0B 2G	**FAX: (250) 425-8727**
☐	**FORDING RIVER OPERATIONS**	BOX 100, ELKFORD, BC V0B 1H0	**FAX: (250) 865-5222**
☐	**GREENHILLS OPERATIONS**	BOX 5000, ELKFORD, BC V0B 1H0	**FAX: (250) 865-3230**

Section A: Employee Authorization *(to be completed by Employee)*

I authorize and instruct my attending physician to fully complete the form below regarding my present condition or illness and return it to the Teck Operation identified above. I also authorize the Teck Operation identified above to contact my attending physician in writing, with me copied, for the limited purpose of clarifying the information that is expressly sought by this form. I authorize my attending physician to respond to any such request in writing with a copy sent to me.

To the extent that Teck is simply seeking to discern my physician's handwriting under Part B of this form, I authorize Teck to contact my physician's office to obtain such information and I authorize my physician's office to provide such information.

Employee Name (please print) _____ Payroll Number _____ Employee Signature _____

Section B: Medical Information *(to be completed by attending Physician)*

Date of first visit for this absence:				
Absence Due to:	Non- Occupational:	# Accident	# Illness	# Hospitalization
	Occupational:	# Accident	# Illness	
(In layman's terms) best describe the patient's current prognosis:				
Complications or possible effects of medication (if any) with potential impacts on the workplace, as discussed with the patient, or any safety concerns:				
Ability to Perform Job:				
Return to Work Status: # Regular Duties # Alternate Duties Return to Work Date:				

Work Restrictions:		
Employee is ***NOT*** capable of:	**Check**	**Comments; if necessary, expand on restrictions**
Sitting		
Walking: Flat Ground		
Uneven Ground		
Repetitive use of injured area		
Lifting/carrying/pushing/pulling: Light		
Moderate		
Heavy		
Climbing ladders		
Climbing stairs		
Working at heights (indicate height)		
Exposure of Injury to: Heat		
Cold		
Dust		
Wet		
Other Restrictions		
Operation of Mobile Equipment		

Duration of Restriction(s): Shifts: #1 # 2 # 3 #4 # 5+	Weeks: #1 # 2 # 3 #4 # 5+
Physician's Name/Address/Phone:	
Signature of Physician:	Date:

MEDICAL ABSENCE FORM

STRICTLY CONFIDENTIAL

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☐	**ELKVIEW OPERATIONS**	RR1, HWY 3, SPARWOOD, BC V0B 2G	**FAX: (250) 425-8727**
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Section A: Employee Authorization *(to be completed by Employee)*

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To the extent that Teck is simply seeking to discern my physician's handwriting under Part B of this form, I authorize Teck to contact my physician's office to obtain such information and I authorize my physician's office to provide such information.

Employee Name (please print) _____ Payroll Number _____ Employee Signature _____

Section B: Medical Information *(to be completed by attending Physician)*

Date of first visit for this absence:				
Absence Due to:	Non- Occupational:	# Accident	# Illness	# Hospitalization
	Occupational:	# Accident	# Illness	
(In layman's terms) best describe the patient's current prognosis:				
Complications or possible effects of medication (if any) with potential impacts on the workplace, as discussed with the patient, or any safety concerns:				
Ability to Perform Job:				
Return to Work Status: # Regular Duties # Alternate Duties Return to Work Date:				

Work Restrictions:			
Employee is ***NOT*** capable of:		**Check**	**Comments; if necessary, expand on restrictions**
Sitting			
Walking:	Flat Ground		
	Uneven Ground		
Repetitive use of injured area			
Lifting/carrying/pushing/pulling:	Light		
	Moderate		
	Heavy		
Climbing ladders			
Climbing stairs			
Working at heights (indicate height)			
Exposure of Injury to:	Heat		
	Cold		
	Dust		
	Wet		
Other Restrictions			
Operation of Mobile Equipment			

Duration of Restriction(s): Shifts: #1 # 2 # 3 #4 # 5+	Weeks: #1 # 2 # 3 #4 # 5+
Physician's Name/Address/Phone:	
Signature of Physician:	Date: