MACHINISTS, FITTERS & HELPERS INDUSTRIAL UNION LOCAL NO. 3 BENEFIT PLAN

WAGE INDEMNITY BENEFITS CLAIM

(Claim must be filed within 30 days of becoming disabled.)

On behalf of Members of
Machinists Local 3
Labourers Local 1204
Riggers Local 643

4250 CANADA WAY,
BURNABY, BC V5G 4W6
www.machinistslocal3benefits.org
Email: wiclaims@datownley.com

Section 1 (To be completed by Member)

1. Member Last Name _____ First Name _____

2. Member Address _____

3. City	4. Province	5. Postal Code	6. Telephone ( )

7. Social Insurance Number	8. Date of Birth (yr/mo/day)	9. Sex	10.
		☐ Male ☐ Prefer not to Disclose ☐ Female ☐ Another Gender	☐ Married ☐ Single ☐ Other

Notice to Member:
Member to complete **Section 1** of this application.
Doctor to complete **Section 2** of this application.
Union/Employer to complete **Section 3.**
✱ **Member MUST sign where indicated in Section 1, 2 and 3 of the application.**
These benefits are taxable. Income Tax will be deducted from your benefit payments.
Any doctor's fee for completion of this form will be reimbursed up to $100 by the Plan, with receipt.

11. Date last worked	12. When did you become totally disabled (unable to work) Date Time A.M./P.M.
13. If hospitalized, give name of hospital	14. Dates confined to hospital IN OUT
15. If returned to work, give date	16. If not, give date you expect to return to work
17. Name of attending physician **(please print)**	18. Doctor's address

19. Nature of disability

20. Accident Information — Complete only if claim is a result of injuries sustained in an accident.

Date of Accident	Time of Accident	Was work being done for an employer at the time of the accident?	If not at work, where did accident happen?
	at A.M. P.M.	☐ Yes ☐ No	

21. Describe how accident happened

22. Are you receiving Employment Insurance Benefits? ☐ Yes ☐ No If Yes, for what amount? _____
weeks in total: For what period? From: To:

23. Have you been self-employed or employed elsewhere during this period of disability? If "YES", explain.

24. Are you entitled to any Disability Income Benefits provided by a government agency? ☐ Yes ☐ No
25. Are you entitled to any Disability Income under any other plan of group insurance? ☐ Yes ☐ No
26. If "YES", give policy number, name and address of the organization providing such benefits:

I understand that D.A. Townley collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

✱ Member Signature _____ Date _____
(This must be signed before claim can be assessed)

Claim Procedures:

1. If you are eligible and covered under the Plan, you may apply for Wage Indemnity benefits. You must be under the ongoing care of a doctor during the period claimed. Your attending physician must certify that you are unable to work due to a non occupational accident or sickness.
2. Complete and sign the information above, and the appropriate section on the reverse, including obtaining authorized employer/union signature in Section 3 of the application.
3. Have your attending physician complete the Statement on Section 2 on the reverse of the application.
4. Send the completed, signed forms to the above address or email: wiclaims@datownley.com
   Your Plan is designed to integrate with Employment Insurance Sick Benefits. The terms of your Plan require you to make application for those benefits as follows:
5. Obtain an Employment Insurance Claim Kit from a Post Office or the Employment Insurance Office. Complete all and submit to your local Employment Insurance Office.
6. If you do not qualify for sick benefits from Employment Insurance, and are certified as being unable to work by your attending physician, your claim will be considered under the Plan. You MUST provide the Plan with official proof that you are not entitled to benefits from Employment Insurance.
7. Direct Deposit is available. Please contact the Plan Administrator for details.

Section 2 (To be completed by Doctor)

PATIENT AUTHORIZATION

Name **(PLEASE PRINT)**

DATE OF BIRTH Year | Month | Day

I hereby authorize the release, to D.A. Townley, my insurer, and my policyholder, of any information required in connection with this claim. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

DATE Year | Month | Day

✱ PATIENT / MEMBER SIGNATURE

(This must be signed before claim is assessed.)

ATTENDING PHYSICIAN'S STATEMENT **(PLEASE PRINT)**

1. Diagnosis of present condition
   (a) Primary

   (b) Additional conditions or complications which might affect duration of absence from work.

2. To the best of your knowledge
   (a) indicate when symptoms first appeared or accident happened — Year | Month | Day
   (b) has patient had same or similar condition ☐ Yes ☐ No If "Yes", please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

4. If patient is/was pregnant, indicate due date or date of confinement. Year | Month | Day

5. Date of hospital admission Year | Month | Day — Date of discharge Year | Month | Day

6. Nature of treatment (eg. date and type of surgery*, treatment including medication, dosage and frequency) *Was this done under General Anesthetic?
   ☐ Yes ☐ No

7. (a) If patient was referred to you, give name of referring physician

   (b) If you have referred patient to a specialist, give name(s) of physicians and provide a copy of consultation reports.

8. (a) Date of first and all subsequent visits during present period of absence from work (year, month, day)

   (b) Were you actively supervising this patient's care during the full period?
   ☐ No If "No", please comment in remarks
   ☐ Yes If "Yes", state frequency ☐ Weekly ☐ Monthly ☐ Other (specify)

9. (a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
   FROM Year | Month | Day — TO: (inclusive) Year | Month | Day

   (b) If still unable to work, give approximate date when patient should be able to return **or** the estimated number of weeks before possible return — Year | Month | Day

10. (a) How does present condition affect patient's ability to work? (eg. restrictions, limitations, proposed surgery etc.)

    (b) Is patient fit for trial return to work on part-time or modified basis?
    ☐ Yes ☐ No If "Yes", indicate date Year | Month | Day

    (c) Is patient a suitable candidate for a vocational rehabilitation program? ☐ Yes ☐ No

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (Print)	Specialty (Print)	Physician's Stamp Here
Telephone Number ( )	Signature	Date yr/mo/day

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Labourers Local 1204
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Section 3 (To be completed by Employer/Union)

4250 CANADA WAY,
BURNABY, BC V5G 4W6
www.machinistslocal3benefits.org
Email: wiclaims@datownley.com

Notice to Member:
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Doctor to complete **Section 2** of this application.
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Member Last Name	First Name
Member Address	

City	Province	Postal Code	Telephone ( )

Social Insurance Number	Date of Birth (yr/mo/day)	Sex	
		☐ Male ☐ Prefer not to Disclose ☐ Female ☐ Another Gender	☐ Married ☐ Single ☐ Other

Date last worked

Name of employer	Group #
Address	Union affiliation (if applicable)

Date last worked and number of hours worked	Has Member been laid off? (if so, when)	Has Member returned to work? (if so, when)	Has employment been terminated? (if so, when)

Is disability due to occupational sickness or injury?	Has claim been filed with Workers' Compensation Board? *(If yes, date filed)*
☐ Yes ☐ No	☐ Yes ☐ No

Occupation:	Average weekly earnings $

Remarks

Signed (employer/union representative)	Date

***IMPORTANT* Please provide a detailed job description on the space provided below.**

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✱ Member Signature _____ Date _____

(This must be signed before claim can be assessed)