

MACHINISTS FITTERS AND HELPERS UNION LOCAL #3 C.L.C. WELFARE PLAN

WAGE INDEMNITY BENEFITS CLAIM

101 - 4190 LOUGHEED HWY.,
BURNABY, BC V5C 6A8

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

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

Section 1 (To be completed by Member)

Registration No.

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	10. <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other

Notice to Member:

Member to complete Section 1 of this application.

Doctor to complete Attending Physician's Statement in Section 2.

Union/Employer to complete Section 3.

***Member MUST sign where indicated in Section 1, 2, and 3 of application.**

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 at _____ A.M. P.M.	Was work being done for an employer at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not at work, where did accident happen?
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 & Associates Ltd. 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 & Associates Ltd. 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)**

<p>Claim Procedures:</p> <ol style="list-style-type: none"> 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. 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. Have your attending physician complete the Statement on Section 2 on the reverse of the application. Send the completed, signed forms to the above address. 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: 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. 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.
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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 & Associates Ltd., 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'S SIGNATURE _____ <i>(This must be signed before claim is assessed.)</i>	

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
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 (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
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5. Date of hospital admission

Year	Month	Day
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 Date of discharge

Year	Month	Day
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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
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 TO: (inclusive)

Year	Month	Day
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 (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
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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
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 (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	
Any charge for completing this form is patient's responsibility.		