

# CLAIM FOR DISABILITY CREDITS

- a. For each day that you are disabled and collecting benefits from Workers' Compensation, your Hour Bank will be credited for up to a maximum as shown in your Plan booklet or pamphlet.
- OR
- b. If your maximum Weekly Indemnity benefit has been paid and you are still totally disabled and, provided this is not in excess of the maximum number of months of disability credits allowed under your Plan, your Hour Bank will be credited for up to the maximum as shown in your Plan booklet or pamphlet.

Please return the completed form to the following address:

*D.A. Townley & Associates Ltd.*  
#101 - 4190 Lougheed Highway  
Burnaby, BC V5C 6A8

## MEMBER'S STATEMENT

<b>Name:</b>	<b>Social Insurance No.</b>	<b>Telephone No</b> (    )
<b>Address</b> ( <i>Number, Street, City &amp; Postal Code</i> )	<b>Date of Birth</b>	<b>Local Union No.</b>
<b>Name of last Employer</b>	<b>WCB Claim No.</b>	<b>Date of Accident or Illness</b>
<b>Date on which I was unable to work due to my injuries or illness:</b>		
<b>If now recovered, date on which I was fit for work:</b>		

I hereby apply for "Disability Credits" to be applied to my Hour Bank in accordance with the regulations as established by the Board of Trustees.

Date: \_\_\_\_\_ Member's Signature:

## ATTENDING PHYSICIAN'S STATEMENT *Please complete this claim form and return it to your patient*

<b>Patient's Name and Address</b>	<b>Year of Birth</b>
<b>Diagnosis</b> (describe complications, if any):	
<b>Is this a Workers' Compensation Board case?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If hospitalized, give name of hospital:</b>	
<b>If referred to you, give name of referring physician:</b>	
<b>Describe procedure(s) performed:</b>	<b>Date:</b>
Date:	
<b>To the best of my knowledge, the patient has been totally disabled (unable to work)</b> From _____ To _____ inclusive <b>IF STILL DISABLED, GIVE APPROXIMATE DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:</b>	
<b>How long was or will the patient be partially disabled?</b>	
From _____ To _____	
Date: _____ <b>Attending Physician's Signature:</b>	

**PATIENT RELEASE:** I hereby authorize the release of any information or records requested in respect of this claim, to D.A. Townley & Associates Ltd., my insurer, and my policyholder, and certify that the information given is true, correct and complete to the best of my knowledge. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis.

Date: \_\_\_\_\_ Signature of Member:

**IF THERE IS ANY CHARGE FOR COMPLETING THIS FORM, IT IS THE RESPONSIBILITY OF THE PATIENT**