# BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

# LONG TERM DISABILITY CLAIM FORM
# PLAN MEMBER'S STATEMENT

**Note**: You must submit proof of disability within six (6) months of your date of disability. Otherwise Long Term Disability benefits will not be payable under the Plan. Submit this completed form to the Boilermakers' National Health and Welfare Plan (Canada) Plan Administration Office.


**Plan Administration Office**
**45 McIntosh Drive, Markham, Ontario L3R 8C7**
**Telephone: (905) 946-2530 Toll Free: 1-800-668-7547 Fax: (905) 946-2535**
**E-mail: disability@boilermakersbenefits.ca**


**Please print and complete all questions on this form**

| PERSONAL INFORMATION | |
|---|---|
| **Member Name**: | _____ |
| **Date of Birth (D/M/Y)**: | _____ |
| **Home Address**: | _____<br>Street Number Street Name City<br>_____<br>Province Postal Code |
| **Home Phone Number:** | _____ |
| **Cell Phone Number:** | _____ |
| **Social Insurance Number:** | _____ |

| LAST JOB HELD BEFORE DISABILITY INFORMATION | |
|---|---|
| **Usual hours per week worked:** | _____ |
| **Hourly Rate:** | $ _____ |
| **Gross Weekly Pay:** | $ _____ |
| **Income Tax Withheld:** | $ _____ |

| LAST JOB HELD BEFORE DISABILITY INFORMATION CONTINUED | |
|---|---|
| **When was the last day you worked prior to your disability? (D/M/Y)** | _____ |
| **When did your disability begin? (D/M/Y)** | _____ |
| **Have you returned to work? (your regular occupation)** | ☐ Yes ☐ No |
| **Have you returned to work? (any other occupation)** | ☐ Yes ☐ No |
| **Date of your return to work in any capacity: (D/M/Y)** | _____ |
| **If not, on what date do you expect to return to work? (D/M/Y)** | _____ |

| INJURY / ILLNESS DETAILS | | |
|---|---|---|
| **Describe your injury or illness:** | _____<br>_____<br>_____ | |
| **When were you first treated for this injury or illness? (D/M/Y)** | _____ | |
| **Were you ever disabled from the same injury or illness before?** | ☐ Yes ☐ No | |
| **If "Yes", did you receive disability benefits from any other source (insurance company, disability income plan, Workers' Compensation, Canada Pension Plan)?** | ☐ Yes ☐ No | |
| **If "Yes", name of benefit provider(s):** | _____ | |
| **Benefits were paid from: (D/M/Y)** | _____ to _____ | |
| **How does your illness or injury prevent you from performing your usual duties?** | _____<br>_____ | |
| **What are the duties of your usual job? (describe in detail)** | _____<br>_____ | |
| **Since the onset of disability, have you been confined to a bed?** | ☐ Yes ☐ No | If "Yes" from _____ to _____ |
| **Since the onset of disability, have you been confined to your residence?** | ☐ Yes ☐ No | If "Yes" from _____ to _____ |
| **What are your present daily activities?** | _____ | |

## IF DISABILITY IS DUE TO AN INJURY, COMPLETE THE FOLLOWING QUESTIONS

| | |
|---|---|
| **When did it happen? (D/M/Y)** | _____ |
| **Time? (specify AM or PM)** | _____ |
| **Where did it happen? (home, work or elsewhere)** | _____ |
| **How did it happen?** | _____<br>_____ |

## JOB DUTY REQUIREMENTS

**Does your job involve:**

| | | |
|---|---|---|
| **The use of machines, tools or equipment?** | ☐ Yes ☐ No | Explain if "Yes": _____ |
| **Technical knowledge or special skills?** | ☐ Yes ☐ No | Explain if "Yes": _____ |
| **Any supervisory responsibility?** | ☐ Yes ☐ No | Explain if "Yes": _____ |
| **Travel?** | ☐ Yes ☐ No | Explain if "Yes": _____ |

**Describe the type and amount of physical activity involved in your job during a typical work day by circling the appropriate number of hours below:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Walking** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |
| **Sitting** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |
| **Standing** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |

## PRIOR EXPERIENCE

**Employment experience prior to your current occupation:**

| Name of Employer | Job Function/Type of Position | Length of Employment |
|---|---|---|
| | | |
| | | |
| | | |

## FORMAL EDUCATION

| School Name and City | | Circle the highest level completed | Degree or Major Subject (if applicable) |
|---|---|---|---|
| Elementary School | | | |
| High School | | | |
| University/College | | | |
| Other | | | |
| Courses or training after leaving school: | | Course Name: _____ | |
| | | Course Content: _____ | |
| | | Length of Course: _____ | |

## PHYSICIAN INFORMATION

| | |
|---|---|
| **Family physician's name, address and phone number** | _____<br>_____<br>_____ |
| **Names, addresses and phone numbers of physicians, other than your family physician, who treated you in connection with your disability (include dates of treatment)** | _____<br>_____<br>_____ |
| **Names and addresses of hospitals in which you have been treated during your disability (include dates of hospitalization)** | _____<br>_____<br>_____ |

## PENSION/DISABILITY INFORMATION

**Have you filed a claim for, or are you currently receiving a pension or disability benefits from any of the following sources? (Please indicate "Yes" if you have filed a claim for this or any other disability from which you have not recovered, and provide the requested details of any pension or disability benefits you are receiving, whether they commenced before or after your current disability date)**

| Name of Plan | I have filed a claim with: | I am receiving benefits from: |
|---|---|---|
| **Canada/Quebec Pension Plan** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Other Pension Plan** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Other Group Policy** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Workplace Safety and Insurance Board or Workers' Compensation** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Employment Insurance** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Automobile Insurance** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Other** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you are receiving pension or benefits from any of the above sources, please complete the following:**

| Source | Benefit Amount | How is the benefit payable? (lump sum, weekly, monthly) |
|---|---|---|
| | | |
| | | |
| | | |

**Please submit a copy of any letter of acceptance or declination you have received or receive in the future as a result of your claim for any of the above sources being approved or declined.**

## VETERANS' AFFAIRS CANADA, VOCATIONAL REHABILITION, ETC.

| | |
|---|---|
| **Have you contacted any agencies regarding your disability? (Veterans' Affairs Canada, vocational rehabilitation, etc.)** | ☐ Yes ☐ No |
| **If "Yes", name of agency, address and date contacted:** | _____<br>_____ |

**You must promptly notify the Plan Administration Office if:**

1) Your medical condition improves and you are able to work, although you have not yet returned to work.
2) You go to work, whether as an employee or as a self-employed person.
3) You apply for benefits under **any** Workers' Compensation Plan or Canada Pension Plan.
4) You are discharged from the hospital, if you are currently hospital confined.
5) You expect to be away from your usual place of residence for an extended period of time.
6) You receive a settlement from an automobile insurance carrier with respect to your disability.

## IMPORTANT NOTE REGARDING THE PLAN'S RIGHT TO RECOVERY

**A "third party" is your own and any other home or automobile insurer, as well as any individual, business, insurer or government agency against whom you may be entitled to claim for loss of income arising from your disability. The Plan reserves the "right of subrogation", which is the right to recover amounts it has paid to you from a third party. If you are entitled, as a result of the incident which caused or contributed to your disability, to recover compensation for loss of income from a third party, the Plan will be subrogated to all your rights of recovery for loss of income up to the total amount of benefits paid or payable to you by the Plan. You will be required to provide full disclosure about the recovery or attempted recovery. In the event that you provide proof to the Benefits Administration Office that you have not recovered full compensation for loss of income, the Plan shall determine the proportion of damages actually recovered and share pro rata in that amount.**

**You should advise your legal counsel of the Plan's right of subrogation, and you should advise the Benefits Administration Office of any proposed settlement before accepting it. Should you elect to settle the matter prior to judicial determination, you should be aware that the sum reached in the settlement will be deemed to be full compensation for your loss of income, and the Plan's right of subrogation will apply. The term 'compensation' includes any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.**

## AUTHORIZATION AGREEMENT

**I hereby agree to refund any monies due to the Boilermakers' National Health & Welfare Plan (Canada) as a result of payment of pension or disability benefits from any source listed in ITEM 21 above in accordance with the terms of the Plan Text.**

**I hereby authorize my employer(s), any insurance company, medical prepayment plan, service organization, licensed physician, medical practitioner, hospital or other medically related facility, the Medical Insurance Bureau or other organization, institution or person to release to, or obtain from, the Boilermakers' National Health & Welfare Plan (Canada) any medical or benefit payment information that may be required to establish the validity of this claim. I authorize the collection, retention and release of my personal information for Plan administration purposes.**

**I certify that the information in this form, and any further verbal or written statement provided by me with respect to this claim is true and complete to the best of my knowledge. I understand that the Benefits Administration Office will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.**

**I authorize the use of my Social Insurance Number (SIN) for the purpose of tax reporting and for the purposes of identification and administration if my SIN is used as my certificate number.**

**A copy of this authorization shall be as valid as the original.**

**Date: _____ Claimant's Signature: _____**

**Witness Name: _____**

***PRIVACY STATEMENT: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal Information will be protected pursuant to the relevant privacy legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, insurers, re-insurers, regulators) in order to manage the Plan and your entitlement to the benefits of the Plan. Questions related to the Privacy Policy of the Plan should be directed to the Plan Administration office.***

# BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)
# LONG TERM DISABILITY CLAIM FORM
# ATTENDING PHYSICIAN'S DISABILITY BENEFIT STATEMENT

**Note**: You must submit proof of disability within six (6) months of your date of disability. Otherwise Long Term Disability benefits will not be payable under the Plan. Submit this completed form to the Boilermakers' National Health and Welfare Plan (Canada) Plan Administration Office.


**Plan Administration Office**
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**E-mail: disability@boilermakersbenefits.ca**


**Please print and complete all questions on this form.**
**Part 1: Completed by the patient**
**Part 2: Completed by the physician**

## PART 1: PATIENT AUTHORIZATION

| | |
|---|---|
| **Patient Name**: | _____ |
| **Date of Birth (D/M/Y)**: | _____ |
| **Home Address**: | _____<br>Street Number Street Name City<br>_____<br>Province Postal Code |

**I attest that I am not currently working or, if I am working, that I have informed the Boilermakers' National Health and Welfare Plan (Canada) Plan Administration Office. I hereby authorize the release to the Boilermakers' National Health and Welfare Plan (Canada) of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purposes of administering the Long Term Disability Plan and assessing my claim.**

**Patient's Signature** _____ **Date (D/M/Y):** _____

## PART 2: ATTENDING PHYSICIAN'S STATEMENT

### 1. Member History

| | |
|---|---|
| **Date symptoms first appeared or accident happened (D/M/Y)** | _____ |
| **Date patient ceased work because of current condition (D/M/Y)** | _____ |
| **Is condition due to an injury or illness arising out of patient's employment?** | ☐ Yes ☐ No ☐ Unknown |
| **Has patient ever had the same or similar condition?** | ☐ Yes ☐ No ☐ Unknown |
| **If "Yes", please state condition:** | _____ |

| PART 2 CONTINUED: ATTENDING PHYSICIAN'S STATEMENT | |
|---|---|
| **Is the condition chronic?** | ☐ Yes ☐ No |
| **If "Yes", what caused an absence from work?** | |
| **Name(s) of another treating physician:** | _____ |
| **2. Diagnosis (including any complications)** | **Please include any consultation reports** |
| **Primary:** | _____<br>_____ |
| **Additional conditions or complications which might affect duration of absence from work:** | _____<br>_____ |
| **Subjective symptoms:** | _____<br>_____ |
| **Objective signs (including results of current x-rays, EKG's or laboratory data, and any relevant clinical findings)** | _____<br>_____ |
| **3. Physical Impairment** | |
| **What physical limitations affect the patient's ability to work?**<br>**(e.g. limitation with respect to lifting, carrying, bending, walking or standing)** | _____<br>_____ |
| **4. Cognitive / Mental Impairment (if appliciable)** | |
| **How does the patient's cognitive or mental impairment affect ability to work?** | _____<br>_____ |
| **What is the DSM IV diagnosis?** | _____ |
| **Has there been a psychiatric referral?** | ☐ Yes ☐ No |
| **If "Yes", what is the first appointment date? (D/M/Y)** | _____ |
| **Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?** | ☐ Yes ☐ No |
| **5. Cardiac (if appliciable)** | |
| **Functional capacity (American Heart Association)** | ☐ Class 1 (no limitation)<br>☐ Class 2 (slight limitation)<br>☐ Class 3 (marked limitation)<br>☐ Class 4 (complete limitation) |

| Cardiac (if appliciable) continued | | |
|---|---|---|
| **Blood pressure (last 2 visits)** | **Systolic** | **Diastolic** |
| | | |

## 6. Treatment

| | |
|---|---|
| **Date of first visit (D/M/Y)** | _____ |
| **Date of latest visit (D/M/Y)** | _____ |
| **Frequency of visits** | _____ |
| **Nature of treatment (including surgery, physiotheraphy and medications prescribed if any)** | _____ |

## 7. Progress

| | |
|---|---|
| **Has the patient:** | Recovered ☐ |
| | Improved ☐ |
| | Not Improved ☐ |
| | Retrogressed ☐ |

## 8. Prognosis

| | |
|---|---|
| **Do you think that your patient will be able to return to work?** | ☐ Yes ☐ No |
| **If "Yes", state approximate date (D/MY/Y)** | _____ |

## 9. Rehabilitation

| | |
|---|---|
| **Is the patient a suitable candidate for further medical rehabilitation services (i.e. cardiopulmonary program, speech therapy, etc.)** | ☐ Yes ☐ No |
| **If "Yes", please specify:** | _____ |
| **Would vocational counseling and/or retraining be recommended?** | ☐ Yes ☐ No |
| **Is the patient suitable for trial employment?** | ☐ Yes ☐ No |
| **If "Yes", please state date (D/M/Y):** | _____ |

## 10. Remarks

| | |
|---|---|
| **Please provide comments and further details which you feel would be helpful** | _____<br>_____ |

| Contact Information | |
|---|---|
| **Name of attending physician** | _____ |
| **Specialty** | _____ |
| **Telephone number** | _____ |
| **Address** | _____<br>Street Number Street Name City<br>_____<br>Province Postal Code |
| **Physician's signature** | _____ |
| **Date** | _____ |

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