



BOILERMAKERS' NATIONAL HEALTH 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 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:	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">Street Number</td> <td style="width: 40%; border: none;">Street Name</td> <td style="width: 30%; border: none;">City</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Province</td> <td style="border: none;">Postal Code</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;"></td> </tr> </table>	Street Number	Street Name	City	_____	_____	_____	Province	Postal Code		_____	_____	
Street Number	Street Name	City											
_____	_____	_____											
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)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you returned to work? (any other occupation)	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	_____ _____ _____	
When were you first treated for this injury or illness? (D/M/Y)	_____	
Were you ever disabled from the same injury or illness before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", did you receive disability benefits from any other source (insurance company, disability income plan, Workers' Compensation, Canada Pension Plan)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	_____ _____	
What are the duties of your usual job? (describe in detail)	_____ _____	
Since the onset of disability, have you been confined to a bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" from _____ to _____
Since the onset of disability, have you been confined to your residence?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	

JOB DUTY REQUIREMENTS

Does your job involve:		
The use of machines, tools or equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain if "Yes": _____
Technical knowledge or special skills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain if "Yes": _____
Any supervisory responsibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain if "Yes": _____
Travel?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Pension Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Group Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Workplace Safety and Insurance Board or Workers' Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Automobile Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 REHABILITATION, 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:

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 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 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 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 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.
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:	<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 30%;">_____</td> <td style="border: none; width: 40%;">_____</td> <td style="border: none; width: 30%;">_____</td> </tr> <tr> <td style="border: none; font-size: small;">Street Number</td> <td style="border: none; font-size: small;">Street Name</td> <td style="border: none; font-size: small;">City</td> </tr> <tr> <td style="border: none;">_____</td> <td colspan="2" style="border: none;">_____</td> </tr> <tr> <td style="border: none; font-size: small;">Province</td> <td colspan="2" style="border: none; font-size: small;">Postal Code</td> </tr> </table>	_____	_____	_____	Street Number	Street Name	City	_____	_____		Province	Postal Code	
_____	_____	_____											
Street Number	Street Name	City											
_____	_____												
Province	Postal Code												
<p>I attest that I am not currently working or, if I am working, that I have informed the Boilermakers' National Health Plan (Canada) Plan Administration Office. I hereby authorize the release to the Boilermakers' National Health 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.</p>													
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has patient ever had the same or similar condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If "Yes", please state condition:	_____

PART 2 CONTINUED: ATTENDING PHYSICIAN'S STATEMENT

Is the condition chronic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If "Yes", what caused an absence from work?	_____
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Name(s) of another treating physician:	_____
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2. Diagnosis (including any complications)	Please include any consultation reports
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Primary:	_____ _____
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Additional conditions or complications which might affect duration of absence from work:	_____ _____
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Subjective symptoms:	_____ _____
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Objective signs (including results of current x-rays, EKG's or laboratory data, and any relevant clinical findings)	_____ _____
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3. Physical Impairment

What physical limitations affect the patient's ability to work? (e.g. limitation with respect to lifting, carrying, bending, walking or standing)	_____ _____
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4. Cognitive / Mental Impairment (if applicable)

How does the patient's cognitive or mental impairment affect ability to work?	_____ _____
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What is the DSM IV diagnosis?	_____
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Has there been a psychiatric referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If "Yes", what is the first appointment date? (D/M/Y)	_____
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Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5. Cardiac (if applicable)

Functional capacity (American Heart Association)	<input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 3 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation)
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Cardiac (if applicable) 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, physiotherapy and medications prescribed if any)	_____

7. Progress

Has the patient:	Recovered <input type="checkbox"/>
	Improved <input type="checkbox"/>
	Not Improved <input type="checkbox"/>
	Retrogressed <input type="checkbox"/>

8. Prognosis

Do you think that your patient will be able to return to work?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please specify:	_____
Would vocational counseling and/or retraining be recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient suitable for trial employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please state date (D/M/Y):	_____

10. Remarks

Please provide comments and further details which you feel would be helpful	_____ _____
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Contact Information

Name of attending physician	_____
Specialty	_____
Telephone number	_____
Address	_____
	Street Number Street Name City

	Province Postal Code
Physician's signature	_____
Date	_____

Privacy Statement: The Boilermakers' National Health Plan (Canada), the Boilermakers' National Pension Plan (Canada) (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator will collect, maintain, use and disclose only the information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.