BOILERMAKERS' NATIONAL BENEFIT FUNDS (CANADA)

Administration Office
45 McIntosh Drive, Markham, Ontario L3R 8C7
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Administration Office
15220-114 Avenue, Edmonton, AB, T5M 2Z2
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Boilermakers' National Pension Fund (Canada) Plan Registration Number 0366708 and Boilermakers' National Health Fund (Canada)

SPECIAL DISABILITY BENEFIT APPLICATION PLAN MEMBER'S STATEMENT

Please submit this completed form to the Boilermakers' National Health Fund (Canada) Benefits Administration Office: 45 McIntosh Drive, Markham, Ontario L3R 8C7

PERSONAL INFORMATION (PLEASE PRINT AND COMPLETE ALL QUESTIONS ON THIS FORM

1. Member's Name: _____ Date of Birth: _____ /_____ /_____
   Day Month Year

2. Address: _____
   Number Street City Province

   _____ _____ _____
   Postal Code Phone Number Social Insurance Number

3. Last Job Held Before Disability: _____

   Usual Hours per Week Worked: _____

4. When was the last day you worked prior to your disability? _____ /_____ /_____
   Day Month Year

   When did your disability begin? _____ /_____ /_____
   Day Month Year

5. Will you ever return to work? (your regular occupation) _____
   (any other occupation) _____

   Date of your expected return to work in any capacity: _____ /_____ /_____
   Day Month Year

Please note the Plan's rules about return to work may result in termination of the Special Disability Benefit.

6. Describe your injury or illness: _____

   _____

   _____

7. When were you first treated for this illness or injury? _____ /_____ /_____
   Day Month Year

8. Were you ever disabled from the same sickness/injury before? ☐ No ☐ Yes

If "Yes", did you receive disability benefits from any other source (insurance company, disability income plan, Workers' Compensation, Canada Pension Plan)? ☐ No ☐ Yes

Name of benefit provider(s): _____

Benefits were paid from: _____ /_____ /_____ to: _____ /_____ /_____
Day Month Year Day Month Year

9. If disability is due to an injury, complete the following questions:

When did it happen? _____ /_____ /_____ Time: _____ a.m. ☐ p.m. ☐
Day Month Year

Where did it happen? At home ☐ At work ☐ Elsewhere (name place) ☐

_____

How did it happen?_____

_____

10. How does your illness or injury prevent you from performing your usual duties? _____

_____

_____

11. What are the duties of your usual job? (Please describe in detail) _____

_____

12. Does your usual job involve:

	Yes	No	Explain all "Yes" answers
a. The use of machines, tools or equipment?	☐	☐	_____
b. Technical knowledge or special skills?	☐	☐	_____
c. Any supervisory responsibility?	☐	☐	_____
d. Travel?	☐	☐	_____

13. 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	Sitting	Standing
0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8

14. Since the onset of your disability, have you been

a. Confined to bed? ☐ No ☐ Yes

If "Yes" from: _____ /_____ /_____ to: _____ /_____ /_____
Day Month Year Day Month Year

b. Confined to home? ☐ No ☐ Yes

If "Yes" from: _____ /_____ /_____ to: _____ /_____ /_____
Day Month Year Day Month Year

15. What are your present daily activities? _____

_____

_____

16. What physical limitations affect your ability to work (e.g. limitation with respect to lifting, carrying, bending, walking, standing)? _____

_____

17. Name, address and phone number of family physician: _____

_____

_____

18. Names, addresses and phone numbers of physicians, other than your family physician, who have treated you in connection with your disability (include dates of treatment):

_____

_____

_____

19. Names and addresses of hospitals in which you have been treated during your disability (include dates of hospitalization):

_____

_____

_____

20. Have you filed a claim for, or are you currently receiving a pension or disability benefit 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.)

Source:	I have filed a claim with:	I am receiving benefits from:
Canada/Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No
Boilermakers' National Pension Plan (Canada)	☐ Yes ☐ No	☐ Yes ☐ No
Boilermakers' National Health Plan (Canada) Weekly Indemnity	☐ Yes ☐ No	☐ Yes ☐ No
Boilermakers' National Health Plan (Canada) Long Term Disability	☐ 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 payable (lump sum, weekly, monthly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Important note: 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.

21. Have you contacted any agencies regarding your disability (Veterans' Affairs Canada, vocational rehabilitation, etc.)? ☐ Yes ☐ No

If "Yes", Name of Agency _____

Address _____ Date _____

YOU MUST PROMPTLY NOTIFY THE BENEFITS ADMINISTRATION OFFICE IF YOU GO TO WORK, OR ANTICIPATE GOING TO WORK, WHETHER AS AN EMPLOYEE OR AS A SELF-EMPLOYED PERSON, WHETHER IN THE BOILERMAKER TRADE OR ANY OTHER EMPLOYMENT.

MEMBER NAME: _____

AUTHORIZATION AGREEMENT

☐ I hereby acknowledge that the Special Disability Benefit will be terminated immediately in the event that I return to work in any aspect of the Boilermaker Trade including but not limited to supervisor, safety, management, or for an employer which participates in the Boilermakers' National Health Fund (Canada) or the Boilermakers' National Pension Fund (Canada). I hereby acknowledge that I must notify the Benefits Administration Office immediately when I return to work.

☐ I hereby acknowledge that the Benefit Administration Office will require information from me, on an annual basis, to verify my employment status. This information may include my Income Tax Return and Notice of Assessment and any supporting documents. My failure to provide any requested information may result in the immediate termination of the Special Disability Benefit and the Trustees have the right to recover any amounts overpaid.

☐ 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 and my membership status with the International Brotherhood of Boilermakers.

☐ I acknowledge that if my Special Disability Benefit is terminated my pension will continue.

☐ 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.

Please initial each box above. A copy of this authorization shall be as valid as the original.

Date: _____ Claimant's Signature: _____

Witness: _____

Privacy Statement: I authorize 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 to collect, maintain, use and disclose my personal 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 my 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.