BOILERMAKERS' NATIONAL HEALTH PLAN (CANADA)

WEEKLY DISABILITY INCOME BENEFIT CLAIM

Note: You must submit proof of disability within six (6) months of your date of disability. Late-filed claims are not accepted. 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.
ENCRYPT ALL ITEMS EMAILED

PERSONAL INFORMATION	
Member Name:	
Date of Birth (D/M/Y):	
Home Address:	Street Number / Street Name / City Province / Postal Code
Home Phone Number:	
Cell Phone Number:	
Email Address:	
Social Insurance Number:	
Member of IBB Local Lodge:	

LAST JOB HELD BEFORE DISABILITY INFORMATION	
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? (to your regular occupation)	☐ Yes ☐ No
Have you worked since your date of disability?	☐ 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:		
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 (for example: insurance company, disability income plan, Workers' Compensation, Canada Pension Plan)?	☐ Yes ☐ No	
If "Yes", name of benefit provider(s):		
Benefits were paid from/to: (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?	☐ 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?		

DISABILITY INFORMATION

Is your disability due to an accident?	☐ Yes ☐ No	
If "Yes", please answer the following questions:		
Was it a motor vehicle accident?	☐ Yes ☐ No	**NOTE: The Plan is the second payor in event of a motor vehicle accident Please refer to your Active Member Health Plan Booklet for more information**
When did it happen?	Day Month Year Time (AM or PM)	
Where did it happen?	☐ Home ☐ Work	Elsewhere (name place) _____
How did it happen?		

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

TREATMENT	
On what date were you first treated by a physician for this disability? (D/M/Y)	_____
List name, address and telephone number of each physician who has treated you for this disability:	_____ _____ _____
Have you been hospitalized in connection with this disability?	☐ Yes ☐ No
If "Yes", please indicate the name of the hospital:	_____
Dates hospitalized (D/M/Y)	From_____to _____

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/Source	I have filed a claim with:	I am receiving benefits from:
Boilermakers' National Pension Plan (Canada)	☐ Yes ☐ No	☐ Yes ☐ No
Canada/Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No
Canada Pension Plan Disability Benefit	☐ 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
Motor Vehicle Insurance	☐ Yes ☐ No	☐ Yes ☐ No
Other	☐ Yes ☐ No	☐ Yes ☐ No

If you do file a claim for disability benefits with anyone, you must advise the Plan in writing.
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.

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 receive benefits under **any** Workers' Compensation Plan or Canada Pension Plan.
5) You are discharged from the hospital, if you are currently hospital confined.
6) You expect to be away from your usual place of residence for an extended period of time.
7) You receive a settlement from a motor vehicle insurance carrier with respect to your disability.

IMPORTANT NOTE REGARDING THE PLAN'S RIGHTS OF RECOVERY

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. I agree to repay such amounts immediately after I am notified of an overpayment.

A "third party" is your own and any other home, property or motor vehicle 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 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 entitled to recover 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 Plan 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.
The Plan may deem a settlement to be future income.

You should advise your legal counsel of the Plan's right of recovery, and you should advise the Plan 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 recovery 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 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, use and disclosure of my personal information for Plan administration purposes.

The above answers are true and complete according to the best of my knowledge and belief. I authorize the Plan Administrator to collect and exchange personal health information about me and/or my dependants to process this claim and administer my group plan. I understand any personal health information obtained by the Plan Administrator will be kept confidential and, where necessary, the Plan Administrator will be exchanging my personal health information. I authorize the following persons to exchange with the Plan Administrator or each other, any of my personal health information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, my union, the Board of Trustees of the Boilermakers' National Health Plan (Canada), government agency, auditing or independent investigative organization or financial institution. I acknowledge that providing my consent will allow access to the information required to assess my benefit eligibility and entitlement, and that refusing to consent may result in delay or denial of my request and/or benefit. This consent may be revoked by me at any time by sending written instructions to the Plan's Administration Office.

I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.
I consent to the collection, use and disclosure of my personal information. ☐ **Yes** ☐ **No**

Member's Signature and consent: _____ **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.

ATTENDING PHYSICIAN'S STATEMENT
PART 1: PATIENT AUTHORIZATION

Member Name:	
Date of Birth (D/M/Y):	

I hereby authorize the release to the Boilermakers' National Health Plan (Canada) Plan Administrator 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 purpose of administering the Weekly Indemnity benefit and assessing my claim. This consent may be revoked by me at any time by sending written instructions to the physician's office.

Patient's Signature: _____	**Date: _____**

ATTENDING PHYSICIAN'S STATEMENT
PART 2: PERSONAL HEALTH INFORMATION

Diagnosis of present condition	
a) Primary	
b) Additional conditions or complications which might affect duration of absence from work	
To the best of your knowledge, indicate when symptoms first appeared or accident happened (D/M/Y)	
Has the patient had the same or similar condition before?	☐ Yes ☐ No
If "Yes", please state when and describe	
Is the condition due to injury or illness arising out of patient's employment?	☐ Yes ☐ No ☐ Unknown
If the patient is/was pregnant, indicate date or expected day of confinement (D/M/Y)	
Date of hospital in-patient admission (D/M/Y)	
Date of discharge (D/M/Y)	
Nature of treatment (e.g. date and type of surgery)	
If the patient was referred to you, give name of referring physician	
If you have referred patient to a specialist, give name(s) of physician	
Date of first visit during present period of absence from work (D/M/Y)	

ATTENDING PHYSICIAN'S STATEMENT
PART 2: PERSONAL HEALTH INFORMATION
CONTINUED

Date of latest attendance (D/M/Y)	
Were you actively supervising this patient's care during the full period?	☐ Yes. State frequency: _____ ☐ No. Comment in remarks.
To the best of your knowledge, indicate period patient has already been unable to work at own occupation as a result of present condition:	From_____to _____
If still unable to work, give approximate date patient has already been unable to work (D/M/Y) or the estimated number of weeks from today before possible return:	
Please advise how present condition affects patient's ability to work (for example: restrictions, limitations, proposed surgery, etc.)	
Remarks (Please provide comments and further details which you feel would be helpful)	
Name of attending physician:	
Specialty:	
Telephone number:	
Address:	_____ Street Number Street Name _____ City, Province Postal Code
Signature of attending physician:	
Date:	