BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

WEEKLY INCOME STATEMENT OF CLAIM

Note: You must submit a complete Weekly Income Statement of Claim form marked "Private" to:

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

MEMBER 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:	_____
Social Insurance Number:	_____
Local Lodge:	_____
Have you worked at any time since the date you were disabled?	☐ Yes ☐ No
On what date were you first disabled and unable to work?	_____ Day Month Year _____ Time (AM or PM)
On what date do you expect to return to work?	_____ Day Month Year
Have you done any type of work at all (for payment) since your date of disability?	☐ Yes ☐ No

DISABILITY INFORMATION

Is your disability due to an accident?	☐ Yes ☐ No
If "Yes", please answer the following questions:	
When did it happen?	_____ Day Month Year _____ Time (AM or PM)
Where did it happen?	☐ Home ☐ Work ☐ Elsewhere (name place) _____
How did it happen?	_____

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 commence 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
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

PENSION/DISABILITY INFORMATION CONTINUED

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

Source	Benefit Amount	Payable (lump sum, weekly, monthly)

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 and Welfare Plan (Canada), government agency, auditing or independent investigative organization or financial institution.

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.

Member's Signature: _____	**Date:** _____

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 the 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.**

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 Benefit 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.

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 physicians	_____
Date of first visit during present period of absence from work (D/M/Y)	_____
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:	

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.