Local 112 Millworkers (**UNIFOR**) **Health & Welfare Plan**
Wage Indemnity Claim Form

Please PRINT clearly in ink, sign and date the form, and return to the Plan Administrator within 90 days of last day worked.

Notice to Employee: Employer to complete appropriate section. Doctor to complete Attending Physician's Statement on reverse if absence is for more than five working days. **If claim is for more than five working days, you must be seen and treated by a Medical Doctor during period of disability and you must sign both sides of form where indicated.** If applicable under the terms of your contract, you will be required to make application for Employment Insurance sick benefits. **As your benefits are taxable, Income Tax will be deducted from your benefit payments**. Direct deposit may be available – contact the Plan Administration Office at questions@millworkersuniforbenefits.org or 1-800-263-3564.

1. MEMBER'S SECTION – to be completed by the EMPLOYEE

Member's Last Name	**Member's First Name**		**Social Insurance Number**	
Address (street number and name)		**Apt. Number**	**Phone Number**	
City	**Province**	**Postal Code**	**Gender**	**Date of Birth** (YYYY-MM-DD)
When did you become totally disabled (unable to work)? **Date:** (YYYY-MM-DD) **Time:**	**Date last worked** (YYYY-MM-DD)		**Date returned to work / expected to return to work** (YYYY-MM-DD)	
Nature of disability				
If accident, where did it occur? ☐ Home ☐ Work ☐ Motor Vehicle Accident ☐ Other: _____	**If accident, describe how it happened:**			
Are you receiving or entitled to receive disability benefits from: Employment Insurance (EI) ☐ Yes ☐ No Another government agency ☐ Yes ☐ No Another group plan ☐ Yes ☐ No	**If yes to any, for what period and amount?** Dates: Amount ($):			
Have you been self-employed or employed elsewhere during this period of disability? ☐ Yes ☐ No **If "Yes", please explain:**				
Privacy Statement: I authorize the Millworkers Health & Welfare and Pension Plans (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				
Employee Signature (This must be signed before claim can be assessed.)			**Date Signed** (YYYY-MM-DD)	

2. EMPLOYER'S SECTION – to be completed by the EMPLOYER

Name of Employer			**Phone Number**
Address			
Date last worked: (YYYY-MM-DD) **Number of hours worked:**	**Date returned or expected to return to work** (YYYY-MM-DD)		**Has employee been laid off / terminated?** ☐ Yes ☐ No **If "Yes", when** (YYYY-MM-DD)
Is disability due to occupational sickness or injury? ☐ Yes ☐ No	**Has claim been filed with Workers' Compensation?** ☐ Yes ☐ No **If "Yes", date filed** (YYYY-MM-DD)		
Occupation	**Current Hourly Rate of pay** **$ per hour**		**Average Weekly Hours Worked (based on past 5 months)***
Regular work days (if irregular indicate days scheduled to work during sickness period) **Week 1:** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday **Week 2:** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday			
Remarks			
Signed (employer's representative)	**Date Signed**(YYYY-MM-DD)		**Contact Email**

* The Employer is requested to provide average weekly hours worked or details of hours worked over the prior 5 months. Once enough hours have been submitted under the Plan, the Administrator will be able to calculate the average hours based on information already on file.

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Page 2 must be completed if absence is for more than five (5) working days

3. PATIENT AUTHORIZATION – to be completed by the EMPLOYEE

Patient's Name (please print)	**Date of Birth** (YYYY-MM-DD)

I hereby authorize the release, to the Plan Administration Office and my insurer, any information required in connection with this claim. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

Patient's Signature	**Date** (YYYY-MM-DD)

4. ATTENDING PHYSICIAN'S STATEMENT

Diagnosis of present condition

Primary

Additional conditions or complications which might affect duration of absence from work

To the best of your knowledge

Date symptoms first appeared or accident happened (YYYY-MM-DD)

Has patient previously had same or similar condition ☐ Yes ☐ No
If "Yes", please state when and describe:

Is condition due to injury/sickness arising out of patient's employment?
☐ Yes ☐ No ☐ Unknown

Is/was patient pregnant? ☐ Yes ☐ No **If "Yes", indicate due date or date of confinement** (YYYY-MM-DD)

Date of hospital admission (YYYY-MM-DD)	**Date of discharge** (YYYY-MM-DD)

Nature of treatment (i.e. date and type of surgery*, treatment including medication, dosage and frequency)	***If surgery, was it under General Anesthetic?** ☐ Yes ☐ No

Name of referring physician, if applicable	**If you've referred to a specialist, give name(s) of physician(s) and provide a copy of consultation reports**

Please list dates of <u>first and all subsequent visits</u> during present period of absence from work (YYYY-MM-DD)

Were you actively supervising this patient's care during the full period?
☐ Yes ☐ No **If "Yes", state frequency** ☐ Weekly ☐ Monthly ☐ Other (specify) **If "No", please comment in remarks below**

Indicate period patient has been unable to work at own occupation as a result of present condition From (YYYY-MM-DD) To (YYYY-MM-DD)	**How does present condition affect patient's ability to work?** (restrictions, limitations, proposed surgery, etc)

If still unable to work, give approximate date when patient should be able to return or the estimated number of weeks before possible return Date (YYYY-MM-DD) or Weeks	**Is patient fit for trial return to work on a part-time or modified basis?** ☐ Yes ☐ No **If "Yes", indicate date** (YYYY-MM-DD)

Remarks – Please provide comments and further details which you feel would be helpful

Name of Attending Physician (Please Print)	**Specialty** (Please Print)	**Physician's Stamp Here**

Signature	**Date** (YYYY-MM-DD)	**Phone Number**

Any charge for completing this form is the patient's responsibility.

PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATION OFFICE

45 McINTOSH DRIVE, MARKHAM, ON L3R 8C7
Phone: 1-800-263-3564 Fax: 905-946-2535
email:questions@millworkersuniforbenefits.org