MILLWORKERS HEALTH & WELFARE PLAN (UNIFOR)

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

Registration No.

WAGE INDEMNITY BENEFITS CLAIM

(Claim must be filed within 30 days of becoming disabled.)

Claim Procedures:

1. If you are eligible and covered under the Plan, you may apply for Wage Indemnity benefits. You must be under the ongoing care of a doctor during the period claimed. Your attending physician must certify that you are unable to work due to a non occupational accident or sickness.
2. Complete and sign the information below, and the appropriate section on the reverse, including obtaining Authorized Union Signature below.
3. Have your attending physician complete the Statement on the reverse.
4. Send the completed, signed form to the above address.

Your Plan is designed to integrate with Employment Insurance Sick Benefits. The terms of your Plan require you to make application for those benefits as follows:

5. Obtain an Employment Insurance Claim Kit from a Post Office or the Employment Insurance Office. Complete all and submit to your local Employment Insurance Office.
6. If you are not qualified for sick benefits from Employment Insurance, and are certified as being unable to work by your attending physician, your claim will be considered under the Plan. You MUST provide the Plan with official proof that you are not entitled to benefits from Employment Insurance.

1. Member Last Name | First Name | 7. Social Insurance Number | 8. Date of Birth (yr/mo/day)

2. Member Address | 9. Sex | 10. ☐ Married ☐ Single ☐ Other

3. City | 4. Province | 5. Postal Code | 6. Telephone # ( )

11. Occupation | 12. Describe job duties fully

13. Date last worked | 14. Employer for whom you last worked prior to disability
Name: _____ Location: _____

15. When did you become totally disabled (unable to work)
Date Time A.M./P.M. | 16. Reason for leaving work prior to disability (sickness, accident, layoff, etc.)

17. If hospitalized, give name of hospital | 18. Dates confined to hospital | 19. Have you recovered?

20. If returned to work, give date | 21. If not, give date you expect to return to work

22. Name of attending physician **(please print)** | 23. Doctor's address

24. Nature of disability

25. Accident Information — Complete only if claim is a result of injuries sustained in an accident.

Date of Accident	Time of Accident	Was work being done for an employer at the time of the accident?	If not at work, where did accident happen?
	at A.M. ☐ P.M. ☐	☐ Yes ☐ No	

26. Describe how accident happened

27. Are you receiving Employment Insurance Benefits? ☐ Yes If Yes, for what amount? _____

28. Have you been self-employed or employed elsewhere during this period of disability? If "YES", explain.

29. Are you entitled to any Disability Income Benefits provided by a government agency? ☐ Yes ☐ No

30. Are you entitled to any Disability Income under any other plan of group insurance? ☐ Yes ☐ No

31. If "YES", give policy number, name and address of the organization providing such benefits:

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

* Member Signature _____ Date _____

* Authorized Union Signature _____ ***(Both must be signed before claim can be asessed)***

For Office Use Only:

The above Member's first eligible month concurrent with or following disability is _____.

Benefit amt. $ _____ Class _____ Administrator's signature _____ Date _____

PATIENT AUTHORIZATION

Name **(PLEASE PRINT)**

DATE OF BIRTH
Year | Month | Day

I hereby authorize the release, the Plan, my insurer, and my policyholder, of 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.

DATE
Year | Month | Day

* PATIENT'S SIGNATURE _____

(This must be signed before claim can be assessed.)

ATTENDING PHYSICIAN'S STATEMENT **(PLEASE PRINT)**

1. Diagnosis of present condition
   (a) Primary

   (b) Additional conditions or complications which might affect duration of absence from work.

2. To the best of your knowledge
   (a) indicate when symptoms first appeared or accident happened — Year | Month | Day
   (b) has patient had same or similar condition? ☐ Yes ☐ No If "Yes", please state when and describe

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

4. If patient is/was pregnant, indicate due date or date of confinement. — Year | Month | Day

5. Date of hospital admission — Year | Month | Day — Date of discharge — Year | Month | Day

6. Nature of treatment (eg. date and type of surgery, treatment including medication, dosage and frequency)

7. (a) If patient was referred to you, give name of referring physician

   (b) If you have referred patient to a specialist, give name(s) of physicians and provide a copy of consultation reports.

8. (a) Date of first and all subsequent visits during present period of absence from work (year, month, day)

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

9. (a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
   FROM — Year | Month | Day — TO: (inclusive) — Year | Month | Day

   (b) If still unable to work, give approximate date when patient should be able to return **or** the estimated number of weeks before possible return — Year | Month | Day

10. (a) How does present condition affect patient's ability to work? (eg. restrictions, limitations, proposed surgery, etc.)

    (b) Is patient fit for trial return to work on part-time or modified basis?
    ☐ Yes ☐ No If "Yes", indicate date — Year | Month | Day

    (c) Is patient a suitable candidate for a vocational rehabilitation program? ☐ Yes ☐ No

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (Print)	Specialty (Print)	Physician's Stamp Here
Telephone Number ( )	Signature	Date (yr/mo/day)

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