UA LOCAL 787 BENEFIT PLANS

Weekly Income
Statement of Claim

Member- Complete this section. Please Print

1. Member's Name_____ Date of Birth_____/_____/_____
Day Month Year

2. Address_____ S.I.N_____
Street City Province
Postal Code_____ Phone No._____

3a. Last Day Worked_____ Have you worked at any time since you were disabled? ☐ Yes ☐ No

3b. On What date were you first disabled and unable to work? _____/_____/_____at _____ ☐ a.m. ☐ p.m.
Day Month Year

On What date do you expect to return to work? _____/_____/_____
Day Month Year

4. Is disability due to an accident? ☐ Yes ☐ No
a. When did it happen?_____/_____/_____
Day Month Year

If "Yes" please answer the following questions
Time_____ ☐ a.m. ☐ p.m.

b. Where did it happen? ☐ At Home ☐ At Work ☐ Elsewhere (name place)_____

c. How did it happen?_____

5. On what date were you first treated by a physician for this disability? _____/_____/_____
Day Month Year

6. List Names and Addresses of physicians who have treated you in connection with this disability.

_____ _____

_____ _____

7. Have you been hospitalized in connection with this disability? ☐ Yes ☐ No
If "Yes", please indicate: Name of Hospital:_____
Date Hospitalized: From_____/_____/_____To _____/_____/_____
Day Month Year Day Month Year

8. Are disability benefits payable from any other source as the result of this sickness or injury? ☐ Yes ☐ No

9. Have you done any type of work at all (for payment) since your date of disability?

_____

The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to and use by the Administrator and/or its Agents of any medical or other information that may be required to establish the validity if this claim and further empower the Administrator and/or its Agents to disclose any personal or claim information needed for medical review or study. A photocopy of this release shall be as valid as the original. I authorize the use of my Social Insurance Number (SIN) for claim identification and income tax purposes only.

Member's Signature_____ Date_____

Benefit Plans Administration Office: 45 McIntosh Drive, Markham, Ontario L3R 8C7
Telephone: 905-946-2220 Toll Free: 1-866-946-2220 Fax: 905-946-2535
E-mail: ebps@mcateer.ca Website: http://www.ualocal787.org Facebook: www.facebook.com/UALocal787Benefits
The Pension Plan's Registration Number is 0491688.

Attending Physician's Statement

1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

Part 1: Patient Authorization

Name: Date of Birth (day, month, year)

I hereby authorize the release to my insurer and my policy holder of any information in respect of this claim.

Patient's Signature Date (day, month, year)

Part 2: Attending Physician's Statement

1. Diagnosis of present condition
   a) Primary

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

2. To the best if your knowledge
   a) indicate when symptoms first appeared accident happened (day, month, year) or

   b) has patient had same or similar condition ☐ No ☐ Yes Please state when and describe.

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

4. If patient is/was pregnant, indicate date or expected day of confinement (day, month, year)

5. Date of hospital in-patient admission (day, month, year) Date of discharge (day, month, year)

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.

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

   b) Were you actively supervising patient's care during full period?
   ☐ No - comment in remarks
   ☐ 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 (day, month, year) To (day, month, year)

b) If still unable to work, give approximate date patient should be able to return or the estimated number of weeks before possible return (day, month, year)

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

11. Do you believe patient is competent to endorse cheques and direct the use of the proceeds thereof?
□ Yes □ No

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

Name of attending physician (please print) Specialty Telephone No.

Address (number, street, city, province, postal code)

Signature Date (day, month, year)

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.