U.A. Local 787 Health Plan

New Short Term Disability Benefit Navigator

Starting with disabilities arising on/after January 1, 2026, the Health Plan's Short Term Disability benefit is integrated with Employment Insurance (EI) sickness benefit. The Health Plan also has a Short Term Disability Top-Up benefit of a maximum of $210 per week. The information below will show you how to apply for these benefits.

Applying

Apply for EI's sickness benefit as soon as you become unable to work due to an illness or disability.

Apply for the Plan's Short Term Disability Top Up benefits as soon as possible after you submit your EI application.

Amounts of Benefit

EI's maximum sickness benefit is $729 per week, effective January 1, 2026. It is adjusted annually.

The Plan's Short Term Disability Top-Up benefit is a maximum of $210 per week, effective January 1, 2026.

Before the Plan pays the full $210 weekly top-up amount, it will carry out a pre-disability earnings test to ensure that EI will not reduce your EI benefit

How to apply for EI's Sickness Benefit

Apply online:
www.canada.ca/en/services/benefits/ei/ei-sickness/apply.html.

The website will guide you through the application process and provide detailed instructions on how to complete the form. The application will take approximately 60 minutes to complete.

How to Apply for Health Plan's Short Term Disability Top-Up

After you apply for EI, contact the Plan Administration Office to receive the Plan forms and information.

The forms - found in the forms section of www.787benefits.ca - must be completed and submitted within 6 months of your date of disability for you to be eligible for benefits.

Before receiving your Short Term Disability Top-Up benefit, you must also complete the Plan's Direct Deposit form.

Additional Information

Employment Insurance
There is a 1-week, unpaid, waiting period before the EI Sickness Benefits commence. You may be entitled to EI Sickness Benefits if:

- You're unable to work for medical reasons
- Your regular weekly earnings from work have decreased by more than 40% for at least 1 week
- You accumulated 600 insured hours of work in the 52 weeks before the start of your claim or since the start of your last claim, whichever is shorter

Your Plan's Short-Term Disability Benefit Information
There is a 1-week, unpaid waiting period for the Plan's Short Term Disability benefit. Once all initial forms are received, the Plan Administration Office will evaluate your claim.

You are eligible for the Short Term Disability Top-Up Benefit if you are covered by the Health Plan and you worked in the last two consecutive months immediately prior to the date you first became disabled.

Workplace Safety & Insurance Board (WSIB)
If your disability is due to your employment, as specified by your physician, the Plan will refer you to WSIB to start a claim. If you are denied by WSIB, the Plan will require a copy of the declination letter to review your claim further. If you are approved by WSIB, contact the Plan Administration Office to inquire about possible Long Term Disability and waiver of premium benefits.

Ending your Claim

If you are cleared to return to work, it is your responsibility to communicate the date to the Plan Administration Office as soon as possible, as disability payments will cease one day prior to your return-to-work date.

If you don't qualify for EI sickness benefits

The chances of you not qualifying for EI Sickness Benefits are very low. You could be declined if you:

1. Do not provide the necessary medical information – in this case, the Plan will not provide a Short Term Disability benefit.
2. Did not have enough hours credits with EI before your date of disability. In this case, you may apply to the Plan for Short Term Disability benefits
3. You had issues with an earlier EI claim (such as providing misleading information). In this case, the Plan will not provide any Short Term Disability benefit.

Taxation

Employment Insurance sickness benefits are taxable

The Plan's Short Term Disability benefits are taxable. Income tax is deducted from the Plan's payments. The Plan will issue the proper tax form in February 2027 and in subsequent years.

Long Term Disability

The Plan's Short Term Disability, including the Top-Up, and EI sickness benefits last for a maximum of 26 weeks.

If you are still disabled after 26 weeks, you may be eligible to transition to the Plan's Long Term Disability (LTD) benefit.

You must apply for LTD benefits within 12 months of the onset of your disability. The Plan suggests you apply 8 weeks before your EI Sickness Benefits runs out.

LTD benefit payments will be made to you for as long as you provide the insurer (Manulife Financial) with proof of total disability as required.

LTD benefits continue until the earlier of your attainment of age 65, your recovery, or your death.

Questions?

Email: info@787benefits.ca

Phone: (905) 946 – 2220 Toll-Free: (866) 946 – 2220

U.A. Local 787 Health Plan

Short Term Disability Benefit Application

Submit this claim form to:

Plan Administration Office

2255 Sheppard Ave. E, Atria 1, Suite 201, Toronto, ON M2J 4Y1

905-946-2220 | 1-866-946-2220 | info@787benefits.ca

If submitting by email please encrypt your document and provide the password under a separate email

Personal Health Information – Member to complete this section

1. Member's Full Name: _____ Date of Birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

2. Last Day Worked: _____

Have you worked at any time since you were disabled? _____ YES _____ NO

If "YES" please indicate the dates worked: _____

On what date were you unable to work due to your medical condition? _____ at _____

Day / Month / Year *Time of Day*

On what date do you expect to return to work? _____

Day / Month / Year

3. Is the disability due to an accident? _____ NO _____ YES If "YES" please answer the following questions

a) When did it happen? _____ at _____

Day / Month / Year *Time of Day*

b) Where did it happen? _____ at home _____ at work _____ Elsewhere (name place) _____

c) How did it happen? _____

4. On what date were you first treated by a physician for this disability? _____

Day / Month / Year

5. List the name, address, and phone number of each physician who has treated you for this disability

_____ _____ _____

_____ _____ _____

6. Have you been hospitalized in connection with this disability? _____ NO _____ YES If "YES" please indicate:

_____ from _____ to _____

Name of Hospital *Day / Month / Year* *Day / Month / Year*

Member – Submit this completed form marked "PRIVATE" to

The U.A. Local 787 Plan Administration Office

2255 Sheppard Ave. E, Atria 1, Suite 201, Toronto, ON M2J 4Y1

Fax: 905-946-2535

Email: info@787benefits.ca (form must be password-protected if sent over email)

7. Have you filed a claim for, or are you currently receiving a benefit 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 benefits you are receiving, whether they commenced 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
Any 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

If you are receiving any amount from any of the above sources, please complete the following:

Source	**Benefit Amount**	**How payable (lump sum, weekly, monthly)**
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Have you done any type of work at all (for payment) since your date of disability? _____ NO _____ YES

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 benefits. 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 U.A. Local 787 Health Plan, government agency, auditing or independent investigative organization or financial institution and legal counsel.

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 U.A. LOCAL 787 HEALTH PLAN DISABILITY TEAM IF:

a) Your medical condition improves, and you are able to work, even if you have not yet returned to work.

b) You go to work, whether as an employee or as a self-employed person.

c) You apply for benefits under any Workers' Compensation Plan or the Canada Pension Plan, or other benefits.

d) You are discharged from the hospital if you are currently hospital confined.

e) You expect to be away from your usual place of residence for an extended period of time.

f) You receive a settlement from an automobile insurance carrier with respect to your disability.

UA LOCAL 787 HEALTH AND VACATION PAY PLAN

2255 Sheppard Ave. E, Atria 1, Suite 201, Toronto, ON M2J 4Y1

DIRECT DEPOSIT AND E-NOTIFICATION REQUEST

☐ INITIAL REQUEST ☐ CHANGE REQUEST

MEMBER PERSONAL INFORMATION

NAME:

ADDRESS:_____

CITY:_____ **PROVINCE:**_____

POSTAL CODE:_____

SOCIAL INSURANCE NUMBER:
(THE USE OF THIS IS PROTECTED BY THE PLAN'S PRIVACY POLICY)

REQUEST FOR DIRECT DEPOSIT OF BENEFITS

To request direct deposit or to modify your banking information, please enclose a void cheque with this request AND complete the information below. In both cases, please sign the authorization.

DEPOSIT TO (BANK OR FINANCIAL INSTITUTION)

ADDRESS OF BRANCH

BRANCH NUMBER	INSTITUTION NUMBER	ACCOUNT NUMBER

As the beneficiary paid under my Health Plan, I hereby authorize UA Local 787 Health Trust Fund to deposit these sums in my bank account, whose particulars appear above, or on the enclosed cheque, until such time as I make a written request to the contrary. I understand that the Fund has no further obligation with regard to the benefits paid in accordance with the request. I also understand that the Fund can, without prior notice, terminate the direct deposit of benefits and issue a cheque to me.

This authorization, which takes effect on date below, is valid for all the other active bank accounts in this or any other financial institution that I may name in the future.

_____ _____ / / /

Member's Signature **Date: (DD/MM/YYYY)**

REQUEST TO SUBSCRIBE TO E-NOTIFICATION FOR DIRECT DEPOSIT

Subscribing to e-notification means you will be notified by email of the status of your Health benefit.

To subscribe to e-notification or to change your email address, please complete the information below. Check off the box that corresponds to the address where you want to receive your notifications. Please select only ONE email address.

Work	**Email Address:**
Home	**Email Address:**

Please mail completed Direct Deposit and E-Notification Request Form and Void Cheque to the Plan Administration Office in the enclosed postage paid envelope.

Privacy Statement: The Plans will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plans. This Personal Information may be disclosed to Trustees, Auditors, Regulatory Authorities and others as necessary for Plan administration. Questions about the Plan's Privacy Policy should be directed to the Recording Secretary, UA Local 787 Health Trust Fund, 45 McIntosh Drive, Markham, Ontario, L3R 8C7, Telephone: (905) 946-2220 Toll Free: (866) 946-2220

Click here to email this form to Administration Office

Attending Physician's Statement (to be completed if EI Sickness benefits are declined)

Instructions: 1. Please Print **2.** Part 1 to be completed by the patient **3.** Part 2 to be completed by the physician

Part 1: Patient Authorization

Full Name: _____ Date of Birth: _____

I hereby authorize the release to the U.A. Local 787 Health Plan 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 Short Term Disability Benefit and assessing my claim.

Signature: _____ Date: _____

Part 2: Attending Physician's Statement:

1. Diagnosis of present condition: a) Primary _____

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

_____

2. To the best of your knowledge, indicate, a) when symptoms first appeared, or the accident happened _____
Day / Month / Year

b) has the patient had the same or a similar condition _____ NO _____ YES, please state when and describe:

_____

3. Is the condition due to injury or sickness arising out of the patient's employment _____ NO _____ YES

4. If the patient is/was pregnant, indicate the date or expected date of confinement _____
Day / Month / Year

5. Date of hospital in-patient admission _____ Date of discharge _____
Day / Month / Year *Day / Month / Year*

6. Nature of treatment (e.g. date and type of surgery): _____

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

b) If you have referred the patient to a specialist, give the name(s) of the physicians _____

8. a) First visit during present period of absence from work date _____ b) Latest attendance date _____
Day / Month / Year *Day / Month / Year*

c) Were you actively supervising this patient's care during the full period: _____ NO (comment in remarks) _____ YES (state frequency)

_____ Weekly _____ Monthly _____ Other (specify): _____

9. a) To the best of your knowledge, indicate the period the patient has already been unable to work at their own occupation as a result of the present condition

From _____ to _____
Day / Month / Year *Day / Month / Year*

b) If still unable to work, give approximate date patient should be able to return to work _____
or the estimated number of weeks from today before possible return: _____

10. Please advise how the present condition affects the patient's ability to work (for example, restrictions, limitations, proposed surgery, etc)

_____

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

_____

Name of attending physician: _____ Specialty: _____

Address: _____

Signature: _____ Date: _____

Privacy Statement: The Plans will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plans. Personal Information will be protected pursuant to the applicable legislation. The Plans may use and exchange information with relevant persons and organizations including the Trustees, institutions, investigative agencies, unions, insurers, re-insurers, auditors, legal counsel, actuaries, payroll/payment providers, Plan administrators, and regulatory authorities in order to manage the Plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.