SHEET METAL WORKERS LOCAL UNION 30 WELFARE PLAN

WEEKLY INCOME STATEMENT OF CLAIM

Personal Health Information

MEMBER – complete this section. Please print.

1. Member's Name: _____ Date of Birth: _____/_____/_____ (Day / Month / Year)

2. Address: _____ (Street / City)

Province _____ Postal Code _____ Phone No. _____

3. Social Insurance Number: _____

4. Last Day Worked: _____

On what date were you unable to work due to your medical condition? On what date do you expect to return to work?

_____/_____/_____ (Day / Month / Year) at _____ a.m. ☐ p.m. ☐ _____/_____/_____ (Day / Month / Year)

4. Is disability due to an accident? ☐ NO ☐ YES If "YES", please answer the following questions.

(a) When did it happen? _____/_____/_____ (Day / Month / Year) 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 name, address and phone number of each physician who has treated you for this disability.

_____ _____ _____

_____ _____ _____

7. Have you been hospitalized in connection with this disability? ☐ No ☐ Yes

If "YES", please indicate: Name of Hospital _____

Dates Hospitalized: FROM _____/_____/_____ (Day / Month / Year) TO _____/_____/_____ (Day / Month / Year)

Member – submit completed Statement of Claim marked "PRIVATE" to:
Sheet Metal Workers Local Union 30 Welfare Plan, Disability Benefits,
45 McIntosh Drive, Markham, Ontario L3R 8C7
Phone: 905-946-2530 or toll free: 1-800-263-3564
Fax: 905- 946-2535

8. **Have you filed a claim for, or are you currently receiving a pension or disability 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 pension or disability 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 any amount from any of the above sources please complete the following:

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

9. **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 Sheet Metal Workers Local Union 30 Welfare Plan, government agency, auditing or independent investigative organization or financial institution and legal counsel.

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 SHEET METAL WORKERS LOCAL UNION 30 WELFARE PLAN DISABILITY BENEFITS ADMINISTRATION 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.**

Attending Physician's Statement

Instructions: 1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.

Part 1: Patient Authorization

Name	Date of Birth (Day/Month/Year)

I hereby authorize the release to the Sheet Metal Workers Local Union 30 Welfare 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 Weekly Indemnity program and assessing my claim.

Patient's Signature _____ Date: _____

Part 2: Attending Physician's Statement: Personal Health Information

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions of 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 (day, month, year)

   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 □ Unknown

4. If patient is/was pregnant indicate date or expected date 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 (e.g. date and type of surgery)

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 visit during present period of absence from work (day/month/year)

   b) Date of latest attendance (day/month/year)

   c) Were you actively supervising this patient's care during the full period: □ No, comment in remarks
   □ Yes, state frequency of visits □ Weekly □ Monthly □ Other (specify)

9. a) 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: _____
   (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: ____ (day/month/year)

10. Please advise how present condition affects 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 (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, legal counsel) 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 Disability Benefits Administrator.