



# BOILERMAKERS' NATIONAL HEALTH AND WELFARE FUND (CANADA)

## LONG TERM DISABILITY CLAIM FORM PLAN MEMBER'S STATEMENT

You must submit proof of disability within six (6) months of your date of disability. Otherwise Long Term Disability benefits will not be payable under the Plan. Submit this completed form to the Boilermakers' National Health & Welfare Fund (Canada) Benefits Administration Office, 45 McIntosh Drive, Markham, Ontario L3R 8C7

### PERSONAL INFORMATION (Please print and complete all questions on this form)

1. Member's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year
2. Address: \_\_\_\_\_  
Number Street City Province  
\_\_\_\_\_  
Postal Code Phone Number Social Insurance Number
3. Last Job Held Before Disability: Usual Hours per Week Worked: \_\_\_\_\_  
Hourly Rate: \$ \_\_\_\_\_ Gross Weekly Pay: \$ \_\_\_\_\_ Income Tax Withheld: \$ \_\_\_\_\_
4. When was the last day you worked prior to your disability? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year  
When did your disability begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year
5. Have you returned to work? (your regular occupation) \_\_\_\_\_ (any other occupation) \_\_\_\_\_  
Date of your return to work in any capacity: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year  
If not, on what date do you expect to return to work? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year
6. Describe your injury or illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. When were you first treated for this illness or injury? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year
8. Were you ever disabled from the same sickness/injury before?  No  Yes

If "Yes", did you receive disability benefits from any other source (insurance company, disability income plan, Workers' Compensation, Canada Pension Plan)?  No  Yes

Name of benefit provider(s): \_\_\_\_\_

Benefits were paid from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year Day Month Year

9. If disability is due to an injury, complete the following questions:

When did it happen? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time: \_\_\_\_\_ a.m.  p.m.   
Day Month Year

Where did it happen? At Home  At work  Elsewhere (name place) \_\_\_\_\_

How did it happen? \_\_\_\_\_

10. How does your illness or injury prevent you from performing your usual duties? \_\_\_\_ \_\_\_\_

11. What are the duties of your usual job? (Please describe in detail) \_\_\_\_\_

12. Does your usual job involve:	Yes	No	Explain all "Yes" answers
a. The use of machines, tools or equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Technical knowledge or special skills?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Any supervisory responsibility?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Travel?	<input type="checkbox"/>	<input type="checkbox"/>	_____

13. Describe the type and amount of physical activity involved in your job during a typical work day by circling the appropriate number of hours below.

Walking	Sitting	Standing
0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8

14. Employment experience prior to your current occupation:

Name of Employer	Job Function/Type of Position	Length of Employment
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Formal education:

School Name and City	Circle Highest Level Completed	Degree or Major Subject
Elementary _____	1 2 3 4 5 6 7 8 9	_____
High School _____	10 11 12 13	_____
University _____	1 2 3 4	_____
Other _____	1 2 3 4	_____

Courses or training after leaving school:

Course	Content	Length of Course
_____	_____	_____
_____	_____	_____

16. Since the onset of your disability, have you been

a. Confined to bed?  No  Yes If "Yes" from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year Day Month Year

b. Confined to home?  No  Yes If "Yes" from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year Day Month Year

17. What are your present daily activities? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

18. Name, address and phone number of family physician: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

19. Names, addresses and phone numbers of physicians, other than your family physician, who have treated you in connection with your disability (include dates of treatment):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. Names and addresses of hospitals in which you have been treated during your disability (include dates of hospitalization):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. 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)

	<u>I have filed a claim with:</u>	<u>I am receiving benefits from:</u>
Canada/Quebec Pension Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Pension Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Group Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Workplace Safety and Insurance Board or Workers’ Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Automobile Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you are receiving pension or benefits from any of the above sources please complete the following:

<u>Source</u>	<u>Benefit Amount</u>	<u>How payable</u> (lump sum, weekly, monthly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Important note: Please submit a copy of any letter of acceptance or declination you have received or receive in the future as a result of your claim for any of the above sources being approved or declined.**

22. Have you contacted any agencies regarding your disability (Veterans’ Affairs Canada, vocational rehabilitation, etc.)?    Yes    No

If “Yes”, Name of Agency \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

**YOU MUST PROMPTLY NOTIFY THE BENEFITS ADMINISTRATION OFFICE IF:**

- a. Your medical condition improves and you are able to work, although 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.
- 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.

## **IMPORTANT NOTE REGARDING THE PLAN'S RIGHT OF RECOVERY**

A "third party" is your own and any other home or automobile insurer, as well as any individual, business, insurer or government agency against whom you may be entitled to claim for loss of income arising from your disability. The Plan reserves the "right of subrogation", which is the right to recover amounts it has paid to you from a third party. If you are entitled, as a result of the incident which caused or contributed to your disability, to recover compensation for loss of income from a third party, the Plan will be subrogated to all your rights of recovery for loss of income up to the total amount of benefits paid or payable to you by the Plan. You will be required to provide full disclosure about the recovery or attempted recovery. In the event that you provide proof to the Benefits Administration Office that you have not recovered full compensation for loss of income, the Plan shall determine the proportion of damages actually recovered and share pro rata in that amount.

You should advise your legal counsel of the Plan's right of subrogation, and you should advise the Benefits Administration Office of any proposed settlement before accepting it. Should you elect to settle the matter prior to judicial determination, you should be aware that the sum reached in the settlement will be deemed to be full compensation for your loss of income, and the Plan's right of subrogation will apply. The term 'compensation' includes any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

## **AUTHORIZATION AGREEMENT**

I hereby agree to refund any monies due to the Boilermakers' National Health & Welfare Plan (Canada) as a result of payment of pension or disability benefits from any source listed in ITEM 21 above in accordance with the terms of the Plan Text.

I hereby authorize my employer(s), any insurance company, medical prepayment plan, service organization, licensed physician, medical practitioner, hospital or other medically related facility, the Medical Insurance Bureau or other organization, institution or person to release to, or obtain from, the Boilermakers' National Health & Welfare Plan (Canada) any medical or benefit payment information that may be required to establish the validity of this claim. I authorize the collection, retention and release of my personal information for Plan administration purposes.

I certify that the information in this form, and any further verbal or written statement provided by me with respect to this claim is true and complete to the best of my knowledge. I understand that the Benefits Administration Office will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.

I authorize the use of my Social Insurance Number (SIN) for the purpose of tax reporting and for the purposes of identification and administration if my SIN is used as my certificate number.

A copy of this authorization shall be as valid as the original.

Date: \_\_\_\_\_ Claimant's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

**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 Benefits Administration Office.



# BOILERMAKERS' NATIONAL HEALTH AND WELFARE FUND (CANADA)

## LONG TERM DISABILITY

### Attending Physician's Disability Benefits Statement

The Member must submit proof of disability within six (6) months of the date of disability. Otherwise Long Term Disability benefits will not be payable under the Plan. Submit the completed form to the Boilermakers' National Health & Welfare (Canada) Benefits Administration Office: 45 McIntosh Drive, Markham, Ontario L3R 8C7

### Part 1: Patient Authorization

**Instructions:**

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

Name	Date of Birth (D/M/Y)
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Address: number	street	city	province	postal code
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I attest that I am not currently working or, if I am working, that I have informed the Boilermakers' National Health & Welfare (Canada) Benefits Administration Office. I hereby authorize the release to the Boilermakers' National Health & Welfare Plan (Canada) 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 purposes of administering the Long Term Disability Plan and assessing my claim.

Patient's Signature \_\_\_\_\_ Date (D/M/Y) \_\_\_\_\_

### Part 2: Attending Physician's Statement

#### 1. History

<b>a. Date symptoms first appeared or accident happened (D/M/Y)</b>	<b>b. Date patient ceased work because of current condition (D/M/Y)</b>	<b>c. Is condition due to injury or sickness arising out of patient's employment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>d. Has patient ever had same or similar condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes – Please state and describe:		<b>e. Is condition considered chronic?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - What precipitated absence from work?
<b>f. Names of other treating physicians:</b>		

**2. Diagnosis (including any complications)**

Please include any consultative reports

a. Primary:

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

c. Subjective Symptoms:

d. Objective signs (including results of current x-rays, EKG's or laboratory data, and any relevant clinical findings):

**3. Physical Impairment**

What physical limitations affect the claimant's ability to work (e.g. limitation with respect to lifting, carrying, bending, walking, standing)?

**4. Cognitive / Mental Impairment (if applicable)**

(i) How does patient's cognitive or mental impairment affect ability to work?

(ii) What is the DSM IV diagnosis?

(iii) Has there been psychiatric referral?  
 No       Yes – date of first appointment (D/M/Y)(iv) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?  
 Yes       No**5. Cardiac (if applicable)**

a. Functional capacity (American Heart Association)

 Class 1 (no limitation)     Class 2 (slight limitation)     Class 3 (marked limitation)     Class 4 (complete limitation)b. Blood pressure (last 2 visits)  
Systolic      Diastolic-  
-

## 6. Treatment

a. Date of first visit (D/M/Y)	b. Date of latest visit	c. Frequency of visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)
d. Nature of treatment (including surgery, physiotherapy and medications prescribed if any)		

## 7. Progress

Has patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Not Improved <input type="checkbox"/> Retrogressed
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## 8. Prognosis

Do you think that your patient will be able to return to work? <input type="checkbox"/> No <input type="checkbox"/> Yes, state approximate date (D/M/Y)
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## 9. Rehabilitation

a. Is patient a suitable candidate for further medical rehabilitation services (i.e. cardiopulmonary program, speech therapy, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes – please specify:	
b. Would vocational counseling and/or retraining be recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Is patient suitable for trial employment? <input type="checkbox"/> No <input type="checkbox"/> Yes – please state date (D/M/Y)

## 10. 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 (D/M/Y)	

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