

**INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 793,  
LIFE AND HEALTH BENEFIT PLAN**

**DISABILITY AND SUPPLEMENTARY HEALTH CARE BENEFITS**

**MEMBER MUST COMPLETE ALL SECTIONS OF THIS FORM WHICH ARE PERTINENT TO THE CLAIM**

Member's Name: \_\_\_\_\_ Social Insurance \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Init. Last  
Member's Address: \_\_\_\_\_  
No. and Street City Province Postal Code  
Member's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Telephone \_\_\_\_\_ Is Address New?  Yes  No  
Day Month Year

**IF CLAIM IS FOR PRESCRIPTIONS OR OTHER COVERED SERVICES, ALL RECEIPTS MUST SHOW DATE OF SERVICE OR PURCHASE AND FULL NAME OF PATIENT AND ATTACH ALL RECEIPTS.**

Claim For: Member \_\_\_\_\_ Spouse \_\_\_\_\_ Children \_\_\_\_\_

**IF CLAIM IS FOR VISION CARE COMPLETE THE FOLLOWING AND ATTACH ALL RECEIPTS.**

Vision Care Claim Is For \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient's Full Name Day Month Year  
Vision Care Claim Is For: Member \_\_\_\_\_ Spouse \_\_\_\_\_ Children \_\_\_\_\_ Date of Receipt \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

**IF CLAIM IS FOR DISABILITY BENEFITS, THE FOLLOWING MUST BE COMPLETED BY MEMBER AND THE REVERSE SIDE OF THIS FORM COMPLETE BY ATTENDING PHYSICIAN.**

Was The Sickness Or Injury Due In Any Way To The Patient's Employment?  Yes  No  
If Yes, Give Full Particulars Below.

First Day of Total Disability \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Last Worked \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_  
Day Month Year Day Month Year

If Disability Is Due To Accident, Date of Accident \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

How Did The Accident Happen?  
\_\_\_\_\_  
\_\_\_\_\_

Are You Receiving Or Applying For Disability Income Under The Unemployment Insurance Act For Any Period Covered By This Claim?  Yes  No

**HAVE YOU ANY OTHER COVERAGE WHICH WOULD PAY BENEFITS FOR THIS CLAIM?**  Yes  No

I authorize Global Benefit Plan Consultants Inc. to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefit Plan Consultants Inc. will be kept confidential and, where necessary, Global Benefit Plan Consultants Inc. will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal 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, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. 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.

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Signature of Member \_\_\_\_\_ Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Day Month Year



# ATTENDING PHYSICIAN'S STATEMENT

Please return completed form to your patient.

1. Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

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

3. Diagnosis of present condition  
(a) Primary  
(b) Secondary (if applicable)  
(c) If appropriate – additional conditions which might affect the duration of disability.

4. To the best of my knowledge  
(a) Symptoms first appeared or accident happened \_\_\_\_\_  
Day / Month / Year  
(b) Patient has had same or similar condition  Yes  No If "Yes," state when and describe

5. Date of hospital in-patient admission \_\_\_\_\_  
Day / Month / Year  
Date of discharge \_\_\_\_\_  
Day / Month / Year

6. If surgery performed, describe.  
Date \_\_\_\_\_  
Day / Month / Year

7. If referred to you, give name of referring physician.

8. (a) Date of first visit for present period of disability \_\_\_\_\_  
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 If "No," please comment in Question 12.  
 Yes If "Yes," state frequency of visits.  weekly  monthly  other (specify) \_\_\_\_\_

9. If condition is due to pregnancy, what is (or was) the expected date of confinement? \_\_\_\_\_  
Day / Month / Year

10. (a) To the best of my knowledge, the patient has been Totally Disabled (Unable to work).  
From \_\_\_\_\_ To \_\_\_\_\_  
Day / Month / Year Day / Month / Year  
(b) If still disabled, give approximate date when patient should be able to return to work. \_\_\_\_\_  
Day / Month / Year  
or, if indefinite, the estimated number of additional weeks before such return. \_\_\_\_\_ additional weeks.

11. How long was or will patient be Partially Disabled? (Able to work part-time at own occupation)  
From \_\_\_\_\_ To \_\_\_\_\_  
Day / Month / Year Day / Month / Year

12. How does present condition affect patient's ability to work?  
Additional remarks \_\_\_\_\_

Physician's name (Print) \_\_\_\_\_ Address \_\_\_\_\_

Telephone No. \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby request settlement of this claim and authorize the release of any information needed for this purpose to I.U.O.E. Local 793, Life and Health Benefit Plan or its authorized representative.

Are you receiving or applying for disability income benefits under the unemployment insurance act for any period covered by this claim?  Yes  No

Date \_\_\_\_\_ Signature of Member \_\_\_\_\_

All Claims to be sent to: **INTERNATIONAL UNION OF OPERATING ENGINEERS, LOCAL NO. 793**  
**LIFE AND HEALTH BENEFIT PLAN**  
**545 WILSON AVE.**  
**TORONTO, ON M3H 1V2**  
**TELEPHONE: (416) 635-6000 FAX: (416) 635-6464**

