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 Benefits 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 Benefits will be kept confidential and, where necessary, Global Benefits 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

04 / 12

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 ____ / ____ / ____ Day Month Year To ____ / ____ / ____ 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 ____ / ____ / ____ Day Month Year To ____ / ____ / ____ 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? n Yes n No

Date ____________________ Signature of Member ____________________

All Claims to be sent to:

INTERNATIONAL UNION OF OPERATING ENGINEERS, LOCAL NO. 793
LIFE AND HEALTH BENEFIT PLAN
88 ST REGIS CRESCENT SOUTH
TORONTO, ON M3J 1Y8
TELEPHONE: (416) 635-6000 FAX: (416) 635-6464

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