British Columbia Life & Casualty Company

# Union Taxable Plan Short Term Disability Claim Form

Before mailing this form, check that:
- All information has been provided. Failure to provide all information may delay this claim.
- Form has been dated and signed by the member, union and physician

You must submit this claim to BC Life by the policy claiming deadline.

Disability & Life Claims Department
PO Box 7000 Vancouver BC V6B 4E1

Telephone 604 419-8040
Toll-free 1 888-275 4672
Fax 604 419-8055

## Member Statement

| Last Name | First Name | Policy Number | Identification Number |
|---|---|---|---|
| | | 900743 | |

| Date of birth (mm/dd/yyyy) | Sex ☐ Female ☐ Male | Phone number (ten digits) |
|---|---|---|
| | | |

Address/city/province/postal code

| Occupation and duties | Average weekly salary |
|---|---|
| | |

| Name of your most recent employer | Date hired (mm/dd/yyyy) | Last day worked (mm/dd/yyyy) |
|---|---|---|
| IUEC LOCAL 82 | | |

Employer's address/city/province/postal code
#3145 - 585 SEABORNE AVENUE, PORT COQUITLAM, BC V3B 0M3

| Have you registered for work with your union local? ☒ Yes ☐ No | Date registered (mm/dd/yyyy) | Have you received or do you plan to receive EI benefits? ☐ Yes ☒ No | Amount per week $ N/A |
|---|---|---|---|
| | | | |

| Is disability due to an occupational injury or illness? ☐ Yes ☐ No | Has a claim been filed with Workers Compensation (WCB) ☐ Yes ☐ No | Date filed (mm/dd/yyyy) | Status/result of WCB claim: |
|---|---|---|---|
| | | | |

| Are you entitled to receive any income from other income replacement plans or sources? ☐ Yes ☒ No | If yes, amount of other income $ | Name of company / details |
|---|---|---|
| | | |

| Complete if you have holidays scheduled or any type of leave during this disability period. ☐ Holidays ☐ Bereavement ☐ Maternity ☐ Leave of Absence | From (mm/dd/yyyy) | To (mm/dd/yyyy) |
|---|---|---|
| | | |

| Date you became unable to work (mm/dd/yyyy) | Date you first saw a doctor after you stopped working (mm/dd/yyyy) | Date you were first able to return to work (mm/dd/yyyy) |
|---|---|---|
| | | |

| Full name of physician | Phone number (ten digits) |
|---|---|
| | |

Physician's address/city/province/postal code

## Accident Information (if your claim is the result of an accident)

| Date of accident (mm/dd/yyyy) | Time of accident ☐ a.m. ☐ p.m. | Where did the accident happen? ☐ Work ☐ Home ☐ Elsewhere | If elsewhere, specify |
|---|---|---|---|
| | | | |

Describe how the accident happened

## Member Consent & Declaration

*I certify the above facts are true and complete and authorize the release to British Columbia Life & Casualty Company ( BC Life) all medical and other information requested to assess my claim for Short Term Disability benefits.*

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

## Union Authorization

| Group | Division | Sub-Division | Class | Effective date of insurance (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

| The member named above is a member of: | Union name | Local number |
|---|---|---|
| | INTERNATIONAL UNION OF ELEVATOR CONSTRUCTORS | 82 |

Remarks

| Authorized official's signature | Title | Date (mm/dd/yy) |
|---|---|---|
| | | |

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PO Box 7000 Vancouver BC V6B 4E1

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Toll-free 1 888-275 4672
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Before mailing this form, check that:
- All information has been provided. Failure to provide all information may delay this claim.
- Form has been dated and signed by the member, union and physician

Accurate assessment of this claim depends on each question being answered in full.
The patient is responsible for any charges made for the completion of this form.

## Attending Physician's Statement

| Patient's name | Date of birth (mm/dd/yy) |
|---|---|
| Primary diagnosis | |
| Secondary diagnosis (if applicable) | |
| How does the present condition affect the patient's ability to work (e.g. restrictions, limitations, proposed surgery)? | |
| Nature of treatment (e.g. medication prescribed, type of treatment, frequency) | |

| Were diagnostic studies made? ☐ Yes ☐ No | Date(s) of studies (mm/dd/yy) | Type of studies and findings |
|---|---|---|

| If the patient was referred to you, give name of referring physician | If you have referred the patient to a specialist, give name(s) of physician and speciality |
|---|---|

| Date you first treated the patient for this condition | (mm/dd/yy) | Date of last treatment | (mm/dd/yy) | If disability is related to pregnancy give expected date of delivery | (mm/dd/yy) |
|---|---|---|---|---|---|

| If hospitalized: | Name of hospital | Dates confined to hospital: | From (mm/dd/yy) | To (mm/dd/yy) |
|---|---|---|---|---|

| What surgery, if any, was performed? | Date of surgery (mm/dd/yy) |
|---|---|

| If disability due to an accident, date the accident occurred: | (mm/dd/yy) | If claim was reported to WCB or WorkSafe BC, or in any way related to patient's occupation, give details |
|---|---|---|

If the patient is receiving a pension, give details of pensionable disability

Dates of visits other than procedures named above. *Check all that apply*.

| | Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 23 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Office | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| To the best of your knowledge, indicate the period your patient has been unable to work at his/her own occupation as a result of the present condition. | From (mm/dd/yy) | To (mm/dd/yy) |
|---|---|---|

| If your patient is still unable to work, give the approximate date he/she should be able to return to work: | (mm/dd/yy) | or, from today, estimated number of weeks to recovery |
|---|---|---|

| Prognosis |
|---|
| Remarks (any details which you feel would be helpful) |

| Physician's name (print) | Address | | Telephone |
|---|---|---|---|
| Speciality | MSC number | Signature | Date signed (mm/dd/yy) |

## Patient's Authorization

*I authorize the release to British Columbia Life & Casualty Company (BC Life) all medical reports and other information requested to assess my claim for Short Term Disability benefits.*

| Signature | Date signed (mm/dd/yy) |
|---|---|