IUPAT LOCAL 177 WELFARE TRUST FUND

WEEKLY DISABILITY BENEFITS STATEMENT

**** WEEKLY DISABILITY CLAIMS MUST BE RECEIVED WITHIN 180 DAYS FROM THE DATE OF DISABILITY ****

MEMBER INFORMATION (TO BE COMPLETED BY MEMBER)

LOCAL UNION	POLICY # 38B90

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH
		☐ Male ☐ Female	(MM/DD/YY)

ADDRESS	CERTIFICATE / SIN

CITY	PROVINCE	POSTAL CODE	PHONE

DATE EMPLOYED (MM/DD/YY)	LAST DAY WORKED (MM/DD/YY)
DATE DISABILITY CAUSED LOST TIME (MM/DD/YY)	DATE RETURNED TO WORK (MM/DD/YY)

Was more than a half day worked? ☐ No ☐ Yes

If no, how many hours worked? _____

Is illness or injury due to occupational causes? ☐ No ☐ Yes

Do you have provincial health coverage? ☐ No ☐ Yes

Job title: _____

Current hourly wage: $ _____ Numbers of Hours Worked Per Week _____

Have you or will you apply for Accident Benefits with your Auto Insurance Carrier? ☐ No ☐ Yes

Have you (or will you) applied/apply for any benefits from any other sources? ☐ No ☐ Yes

If Yes, what is the amount of the benefit received and from where? $_____

A copy of your tax return may be required at the request of the Administrator.

TO BE COMPLETED BY MEMBER

1. Reason for leaving work (check one):
   ☐ Disability ☐ Leave of Absence ☐ Strike ☐ Temporary Layoff ☐ Regular Layoff ☐ Dismissed ☐ Quit ☐ Retired

2. Is condition due to work related accident or illness? ☐ No ☐ Yes
   Has a claim been filed with WCB? ☐ No ☐ Yes If Yes, claim number_____
   Are you presently receiving Workers' Compensation Benefits? ☐ No ☐ Yes
   If work related but no claim filed, please provide reason _____
   _____
   _____

3. Has a claim been filed with Employment Insurance for regular EI benefits? ☐ No ☐ Yes
   Are you presently receiving EI regular benefits? ☐ No ☐ Yes
   Has a claim been filed with EI for Sickness and Accident benefits? ☐ No ☐ Yes
   Are you presently receiving EI Sickness and Accident benefits? ☐ No ☐ Yes
   If yes, please provide a copy of all your EI Sickness and Accident paystubs.

4. Plan Member's current basic weekly earnings $_____ ☐ Tax Exempt ☐ Basic ☐ Other

5. Do you expect to return to work? ☐ No ☐ Yes If yes, give approximate date _____ (dd/mm/yy)

6. Is modified or part time work available? ☐ No ☐ Yes

7. Prior to the last day worked, were you currently working (please check one of the following):
   ☐ Full Time ☐ Part Time ☐ Full time on modified duties ☐ Part time on modified duties

8. If modified, from what date _____ (dd/mm/yy) Was it a result of work related accident/illness? ☐ No ☐ Yes

9. Please provide a brief job description _____

_____

_____

10. If disability benefits are payable from any other source, please identify and state amount. $_____ Source:_____

11. Please furnish any other information you believe is pertinent to this claim. _____

_____

_____

12. On what date were you first unable to work? _____ at ☐ A.M. ☐ P.M.
(dd/mm/yy)

13. On what date do you expect to return to work?_____
(dd/mm/yy)

14. Have you discussed modified duties or a part time return to work with your physician? ☐ No ☐ Yes

What was his/her response? _____

15. Is your disability due to an accident? ☐ No ☐ Yes If yes, please answer the following questions:
When did it happen? _____ at _____ ☐ A.M. ☐ P.M.
Where did it happen? ☐ at home ☐ at work ☐ other (name place) _____

How did it happen? _____

_____

Was the accident reported to the police? ☐ No ☐ Yes
If yes please provide name of police officer and address of detachment and provide copy of police report _____

_____

Are you taking action against a third party? ☐ No ☐ Yes If yes, provide your lawyer's name and address.

Name: _____ Address:_____

List names and addresses of physicians (other than the physician who completed the claim form) who have treated you in connection with this condition _____

16. Have you been hospitalized for this condition? ☐ No ☐ Yes

If yes, date hospitalized _____ to _____
(dd/mm/yy) *(dd/mm/yy)*

RECOVERY COSTS FROM A THIRD PARTY – (YOU MUST ANSWER EACH QUESTION)

(A) If this claim is as a result of an injury you must complete the following.

(See" Recovery Cost from a Third Party" section on the enclosed Weekly Disability Benefit information sheet)

I, _____ do hereby state that, as a result of my disability, **a claim has been made, or should a claim be made, against a Third Party.**

I understand that any payment made to me by the Trust Fund as a result of this disability is considered "an advance".

In consideration of receiving benefits from the Plan **I, _____, agree to fully reimburse the Plan from any monies I receive from any third party, insurer, or other source whatsoever arising out of the matter for which I received the benefits** and that **I fully understand the reimbursement shall be free of any deductions for any expense I may have incurred to recover same.**

Required for all injury claims

Signature: _____

(B) Are you ***receiving*** or have you ***applied*** for Disability Benefits from any source below:

(Place check mark below)

CANADA PENSION PLAN	☐ Receiving	☐ Applied	☐ Neither
WORKERS' COMPENSATION	☐ Receiving	☐ Applied	☐ Neither
EMPLOYMENT INSURANCE	☐ Receiving	☐ Applied	☐ Neither
RETIREMENT PENSION	☐ Receiving	☐ Applied	☐ Neither

WEEKLY DISABILITY BENEFITS STATEMENT

If you have indicated that you are "receiving" to any – please provide the following information:

Name of Program:	Payment Amount:	Payment Dates:	Began	Ended

If you have indicated that you have "applied" to any of the above please provide **name of program** and **date applied**:

Name of Program:	Date Applied:

Please provide copies of any correspondence from CPP, EI or WCB

(C) Have you any other source of income not mentioned above? ☐ NO ☐ YES

If yes, provide details below:

_____

_____

_____

DECLARATION AND AUTHORIZATION

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize Ellement, Beneva, Homewood Health Inc. and the Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Ellement, Beneva, Homewood Health Inc. and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where Ellement, Beneva, Homewood Health Inc. and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with Ellement, Beneva, Homewood Health Inc. or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize Ellement, Beneva, Homewood Health Inc. or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for Ellement, Beneva, Homewood Health Inc. or the Trust Fund. A copy of this authorization shall be valid as the original.

SIGNATURE OF MEMBER

DATE (MM/DD/YY)

Return Original Form To: Ellement Consulting Group
1050-11150 Jasper Ave NW, Edmonton AB T5K 0C7
E-mail: painters@ellement.ca | Website: www.paintersbenefits.ca
Phone: (780) 587-855-3122 | Toll Free: (877) 641-3122 | Fax: (780) 452-5388

IUPAT LOCAL 177 WELFARE TRUST FUND

ATTENDING PHYSICIAN'S STATEMENT

Please provide all information and documentation as requested on this form so that we can better understand the extent of your patient's condition and the resulting impairments. The information provided will form the basis upon which entitlement to benefits will be assessed

**** COMPLETION OF THIS FORM AND SUBSEQUENT FORMS IS THE RESPONSIBILITY OF THE CLAIMANT ****

All information on this form should be clearly printed

PATIENT INFORMATION

LOCAL UNION			POLICY # 38B90
LAST NAME	FIRST NAME	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
CITY	PROVINCE	POSTAL CODE	PHONE

PHYSICIAN INFORMATION

LAST NAME	FIRST NAME		
ADDRESS			
CITY	PROVINCE	POSTAL CODE	SPECIALTY
PHONE	FAX	EMAIL ADDRESS	

DIAGNOSIS OF PRESENT CONDITION (PLEASE PRINT)

1.

a) Primary _____

b) DSM IV terminology codes:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

c) Secondary _____

d) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

e) Please enclose copies of the following documents in support of the stated diagnosis:

☐ consultation notes ☐ test/investigation reports ☐ assessment reports

☐ clinical notes ☐ psychological testing reports ☐ hospital admission history

☐ operative reports ☐ other _____

2. To the best of your knowledge, indicate when symptom(s) first appeared _____ (dd/mm/yy)

(a) Patient has been unable to perform his/her duties since _____ (dd/mm/yy)

3. Has the patient had same or similar condition? ☐ No ☐ Yes

If yes, please state when and describe.

_____

_____

4. Please state all current symptoms on which your diagnosis is based

_____

_____

_____

_____

5. Current Impairments

(i) Physical Impairment - please check:
☐ Class 1 (no impairment – capable of strenuous physical activity)
☐ Class 2 (slight limitation – capable of moderate activity)
☐ Class 3 (moderate limitation – capable of light activity)
☐ Class 4 (marked limitation – capable of minimal activity)
☐ Class 5 (severe limitation – incapable of minimal activity)

(ii) Is your patient:
☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

(iii) Is your patient capable of:
☐ Lifting _____ kgs/lbs ☐ Sitting _____ ☐ Walking _____ ☐ Squatting _____ ☐ Standing _____ ☐ Bending _____ ☐ Climbing_____

(iv) Does your patient require assistive devices? If yes, please specify_____

(v) Psychiatric Impairments – please check:

☐ Class 1 (able to function under stress and engage in interpersonal relationships – no limitations)
☐ Class 2 (able to function in most stress situations and engage in most interpersonal relationships – slight limitation)
☐ Class 3 (able to engage in only limited stress situations and limited interpersonal relationships – moderate limitation)
☐ Class 4 (unable to engage in stress situations or engage in interpersonal relationships – marked limitation)
☐ Class 5 (patient has significant loss of psychological and social abilities – severe limitation)

(vi) How does your patient's psychiatric disorder affect his/her ability to work?

_____

_____

6. Please provide specific restrictions and limitations.

_____

_____

7. Other factors influencing condition (for example – work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional license etc.) _____

8. Is there an alcohol or substance abuse problem? ☐ No ☐ Yes If yes, please specify treatment center and program details.

_____

_____

9. Current medications. Please specify names of drugs, dosages, start dates and duration.

_____

_____

_____

_____

Response to treatment: _____

_____

10. Other treatment – for example, physiotherapy, counseling, day treatment programs. Please specify type, frequency and full name of facility.

_____

_____

_____

_____

Response to treatment:

_____

_____

11. Dates Hospitalized (recent) Admission Date _____ (dd/mm/yy) Discharge Date_____ (dd/mm/yy)

Institution: _____ Reason: _____

12. Compliance: Is your patient following the recommended treatment program? ☐ No ☐ Yes If no, please explain:

_____

Please state frequency of visits: ☐ weekly ☐ monthly ☐ other, please specify _____

Date of first visit and all subsequent visits during present period of absence from work:

_____

Please provide details of any proposed treatment plan including any recommended surgery.

_____

Have you referred your patient to any other physician? ☐ No ☐ Yes If yes, please provide the full name and specialty

_____

13. What do you understand your patient's occupation to be? _____

Are you familiar with the requirements of your patient's occupation? ☐ No ☐ Yes If yes, please comment

_____

Has your patient expressed a desire to return to work? ☐ No ☐ Yes If yes, please comment

_____

What are your patient's specific work restrictions / limitations? _____

_____

Please confirm the date your patient was/will be capable of returning to the workforce (dd/mm/yy)

☐ To Own Occupation _____ ☐ To any other occupation _____

14. Is your patient competent to endorse cheques and direct the use of the proceeds? ☐ No ☐ Yes
If no, from what date? _____(dd/mm/yy)

15. Has your patient's professional license, certification, driver's or other license been ☐ Restricted ☐ Suspended ☐ Revoked

If yes, date (dd/mm/yy) _____ Type of license _____ Class _____

16. Additional Remarks:

17. Have you provided medical information on your patient's behalf for other benefits? If yes, please provide the full name of the company

_____

_____

PHYSICIANS DECLARATION

I declare that the information on this statement is true to the best of my knowledge.

_____ _____

Physician's Signature (in full) Date: (dd/mm/yy)

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IUPAT LOCAL 177 WELFARE TRUST FUND

ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENT

MEMBER INFORMATION			
LOCAL UNION		POLICY # 38B90	
LAST NAME	FIRST NAME	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
CITY	PROVINCE	POSTAL CODE	PHONE

TO: Ellement on behalf of the IUPAT Local 177 Welfare Trust Fund

AND TO: The Member

IN CONSIDERATION of Ellement (on behalf of the IUPAT Local 177 Welfare Trust Fund) agreeing to pay me a weekly disability benefit, I agree that if I am subsequently found not to be entitled to receive a weekly benefit or to have received an overpayment of the benefit that I will, on demand of Ellement, repay to Ellement (on behalf of the IUPAT Local 177 Welfare Trust Fund) the amount of such overpayment.

I acknowledge that an overpayment to me may result if, for example, I am not eligible under the Rules of the Policy for a weekly disability benefit. Additionally, if I am entitled to benefits under Workers' Compensation or a sickness or regular benefit from Employment Insurance, or SGI Accidental Benefits claim, I would be excluded from receiving weekly disability under this Plan. These examples would exclude payments received from an individual disability policy. I acknowledge that an overpayment to me may result, if I apply for and receive any Pension benefits (Including a pension for the IUPAT Local 177 Pension Trust Fund) during the same period I am eligible for Weekly Disability benefits. I acknowledge that the foregoing are examples of why I may not be entitled to receive a full weekly disability benefit from Ellement and that there may be other reasons why I am not entitled to receive from Ellement that full benefit.

Accordingly, I agree to repay the amount of such overpayment upon demand by Ellement.

DATED at the City of_____, in the Province of _____,

this _____ day of _____, 20____.

SIGNED IN THE PRESENCE OF:

_____ _____

Signature of Witness Signature of Member

_____ _____

Name Name

Address & Phone Number

_____

_____

IUPAT LOCAL 177 WELFARE TRUST FUND

CONSENT TO RELEASE

MEMBER INFORMATION			
LOCAL UNION		POLICY # 38B90	
LAST NAME	FIRST NAME	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
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I hereby expressly consent, authorize and direct:

- Workers' Compensation Board
- Employment Insurance
- Medical Practitioners I have attended
- Representative from the IUPAT Local 177 Welfare Trust Fund
- A center for treatment of addictions that I have attended or will attend

to disclose any knowledge and information requested by the IUPAT Local 177 Welfare Trust Fund, in respect to my Weekly Disability Benefit Claim.

DECLARATION AND AUTHORIZATION

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize Ellement, Beneva, Homewood Health Inc. and the Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Ellement, Beneva, Homewood Health Inc. and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where Ellement, Beneva, Homewood Health Inc. and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with Ellement, Beneva, Homewood Health Inc. or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize Ellement, Beneva, Homewood Health Inc. or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for Ellement, Beneva, Homewood Health Inc. or the Trust Fund. A copy of this authorization shall be valid as the original.

SIGNATURE OF MEMBER _____ DATE (MM/DD/YY) _____

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