British Columbia Life & Casualty Company

Claim for Short Term Disability Benefits

USW-Coastal Forest Industry Health & Welfare Plan

PO Box 24715 Stn F
Vancouver BC V5N 5T8

Telephone: 604 419-8080
Toll free: 1 888 275-4672

Fax: 604 419-8099

Short Term Disability Benefits are self-insured by the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan

Notice of claim must be given no later than 20 days following the first day of illness or accident, and proof submitted withing 90 days.
Have the attending physician complete the back of this form and then return it to your employer.

Employee's Statement

Name	Address / City/province/postal code
Job classification or title	❑ Permanent address ❑ Mailing address / Daytime phone number (ten digits)
Local union number / Date of accident or start of sickness	1. Physician's name and address
Date last worked (yyyy-mm-dd) / Date of first treatment (yyyy-mm-dd)	2. Physician's name and address
Is claim being made for WorkSafeBC? ❑ Yes ❑ No	3. Physician's name and address
Nature of sickness or injury	Date you returned to work (yyyy-mm-dd) / If you have not returned to work, what is expected return date?
If injured, where did accident happen?	School grade reached / Previous job held
Describe accident	Give a brief summary of your education and work experience (attach sheet if more space is needed)

I certify that the above statements are correct and hereby authorize my physician and hospital to give BC Life, FIDAS - Forest Industry Disability Adjudication Services, the Trustees of the USW-Coastal Industry Health & Welfare Plan and the Trustees of the IWA Forest Industry LTD Plan any additional information required in connection with this claim.

I understand that my benefits will be reduced by Federal Income Tax withholding of (choose one) ❑ 10% ❑ 15% ❑ 20%

Employee's signature / Date (yyyy-mm-dd)

Employer's Statement

Group number 008942	Name of Employer	Division	Sub Division	Phone #
Employee's name	Identity number/Social Insurance Number	Job classification	Date of birth (yyyy-mm-dd)	❑ Male ❑ Female
Brief description of job duties (attach sheet if more space is needed)				
For stat holiday purposes does employee work as a logger? ❑ Yes ❑ No				

Date employee last worked (yyyy-mm-dd)

Has employee returned to work? ❑ Yes ❑ No

If yes, date of return (yyyy-mm-dd)

Is this claim one which might come under WorkSafe BC or Occupational Disease Regulation? ❑ Yes ❑ No

If Yes, attach copies of relevant WorkSafeBC correspondence.

Have you any reason to question the validity of this claim? ❑ Yes ❑ No

If Yes, state reason(s)

At the start of disability, the employee was:

❑ Working full time (with regular days off)

Circle days off if employee works alternative shifts: Sun Mon Tue Wed Thu Fri Sat

❑ Laid off work — Date layoff commenced (yyyy-mm-dd) / Number of months coverage entitlement due to seniority

❑ On leave of absence — From (yyyy-mm-dd) / To (yyyy-mm-dd)

Reason

Is leave for extended vacation or apprenticeship training? ❑ Yes ❑ No

❑ On vacation with pay — From (yyyy-mm-dd) / To (yyyy-mm-dd)

I certify that the above statements are correct.

Signed for the Employer by (print name)

Signature / Date (yyyy-mm-dd)

0572.004 50-60-120 06/11 CUPE 1816

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

Physician's Statement

Patient's name	Age

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 (yyyy-mm-dd)	Type of studies and findings

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

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

If hospitalized, name of hospital	Dates confined to hospital, from (yyyy-mm-dd)	To (yyyy-mm-dd)

What surgery, if any, was performed	Date of surgery (yyyy-mm-dd)

If disability is due to an accident, date accident occurred	If claim was reported to WorkSafeBC, or in any way related to the patient's occupation, give details

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

Check dates of visits, exclusive of above procedures.

	Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Office																																	
Hospital																																	
Home																																	

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

Approximately when should patient be able to return to work?	Date (yyyy-mm-dd)	Or number of weeks

Prognosis

Remarks (Provide any details which you feel would be helpful.)

Physician's name (print)	Speciality	MSC number

Address / city / province / postal code	Telephone number (ten digits)

Signature	Date (yyyy-mm-dd)

Patient Authorization

I hereby authorize the release to BC Life, FIDAS - Forest Industry Disability Adjudication Services, the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan and the Trustees of IWA Forest Industry LTD Plan, any additional information requested with respect to this claim.

Signature	Date (yyyy-mm-dd)

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