

## **Claim for Short Term Disability Benefits**

## **USW-Coastal Forest Industry** Health & Welfare Plan



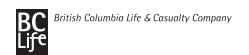
PO Box 24715 Stn F Vancouver BC V5N 5T8 Telephone: 604 419-8080 Toll free: 1 888 275-4672

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 Sta	tement															
Name		Address			City/prov	ty/province/postal code										
Job classification or title				☐ Permanent	address	☐ Mailin	g address	Daytime	phone number (ten digits							
Local union number	Date of accident or star	rt of sickness		Physician's name an	nd address											
Date last worked (yyyy-mm-dd)	Date of first treatment (	(yyyy-mm-dd)		2. Physician's name an	nd address											
				3. Physician's name an	nd address											
Is claim being made fo	or WorkSafeBC?			Date you returned to w	hat is expe	t is expected return date?										
Nature of sickness or injury				School grade reached				Previous	job held							
If injured, where did accident happ	pen?			Give a brief summary of	of your educat	tion and work ex	perience (attach sheet if	f more space is r	needed)							
Describe accident																
I certify that the above physician and hospita Adjudication Services	I to give BC Life	, FIDAS -	Forest	Industry Disabilit	ty 1 _	withholding	g of (choose one		reduced by Feder		me Tax					
& Welfare Plan and th additional information					ny	Employee's sign	nature				Date (yyyy-r	nm-dd)				
Employer's Sta	atement															
Group number 008942	Name of Employer						Division	Sub	Division	Phone 7	#					
Employee's name		Identity num	ber/Social	I Insurance Number	Job classi	ification		Date	of birth (yyyy-mm-dd)	□ м	ale 🔲	Female				
Brief description of job duties (atta	ach sheet if more space is	s needed)								1						
For stat holiday purpor	ses does employ	yee work a	s a log	gger? 🔲 Yes	☐ No											
Date employee last wo	orked (yyyy-mm-	dd)	At the	e start of disability	y, the em	ployee was	3:									
Has employee returne	□ w	☐ Working full time (with regular days off)														
Yes No	С	Circle days off if employee works alternative shifts: Sun Mon Tue Wed Thu Fri Sat														
If yes, date of return (yyyy-mm-dd			La	aid off work		Date layoff co	)	Number of months coverage entitlement due to seni								
Is this claim one which WorkSafe BC or Occu			_ o	n leave of absence	ce	From (yyyy-m	m-dd)		To (yyyy-mm-dd)							
Regulation?  Yes	_		Reason													
If Yes, attach copies of correspondence.	relevant WorkSa	ateBC														
Have you any reason to of this claim?		alidity	ls	Is leave for extended vacation or apprenticeship training?   Yes  No												
If Yes, state reason(s)	NO			n vacation with p												
				certify that the above statements are correct.												
				for the Employer by (print		470 001										
			Signatu	ıre					Date (yyyy-mm-dd)							



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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

Patient's name	n's Stat												_		_		_								Ag	e	_			
	imary diagnosis																													
Primary diagnosis																														
Secondary diagno	sis (if applicable)																													
How does the pre	sent condition affe	ect the patient's ab	oility to work	(e.g. restri	ctions,	limitati	ions, pr	opose	d sur	gery)																				
Nature of treatmer	nt (e.g. medication	n prescribed, type	of treatment	, frequenc	/)																									
Were diagno				☐ No	Da	ate(s)	of studi	ies (yyy	/y-mr	m-dd)		oe of s																		
If patient was refer	red to you, name	of referring physic	cian								lf y	ou hav	ve refe	erred p	atient	to a s	specia	list, nar	ne(s) c	of phy:	sician	and s	peciality	/						
Date you first treated the patient for this condition (yyyy-mm-dd)  If hospitalized, name of hospital									dd)		If disability is related to pre										oregnan	regnancy, expected delivery date (yyyy-mm-dd)								
If hospitalized, nar	ne of hospital											Date	s con	fined t	o hos	pital, f	rom (	yyyy-mi	m-dd)			То (	yyyy-mi	m-dd)						
What surgery, if ar	ny, was performed																					Dat	ate of surgery (yyyy-mm-dd)							
If disability is due t	to an accident, da	te accident occurr	red If cla	im was rep	orted t	o Worl	kSafeB	C, or in	any	way re	elated t	to the	patien	nt's occ	cupati	on, giv	ve det	ails												
If patient is receivi	ng a pension, give	e details of pension	nable disabil	ity																										
Check dates						_	_			40		40	40		4-	40	4-	40	40		0.1							00 /		
Office	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 2	9 3	0 31
Hospital																												$\top$		
Home																														
To the best	of your know	wledge, indi	cate the	period	that	the	patie	nt h	as k	oeen	una	able		From	(уууу	-mm-c	dd)						То (ууу	y-mm-	dd)					
to work at h	is or her ow	n occupatio	n as a re	sult of	the p	ores	ent c	ondi	tior	า.																				
Approximate	ely when sh	ould patient	be able	to retu	ırn to	woı	rk?							Date (yyyy-mm-dd) Or nur								umber of weeks								
Prognosis																														
Remarks (Provide	any details which	you feel would be	e helpful.)																											
Physician's name	(print)									Sp	pecialit	у											N	MSC n	umbe	er				
Address / city / pro	ovince / postal cod	de																					1	Telephone number (ten digits)						
Address / city / province / postal code													Date (yyyy-mm-dd)																	
Signature																								Date (y	yyy-n	nm-dc	i)			

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)