WEEKLY DISABILITY BENEFITS STATEMENT

BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

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

MEMBER INFORMATION

LOCAL UNION		POLICY # 6128	
LAST NAME	FIRST NAME	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
CITY	PROVINCE	POSTAL CODE	PHONE

DATE EMPLOYED (MM/DD/YY)	LAST DAY WORKED (MM/DD/YY)	Was more than a half day worked? ☐ No ☐ Yes If no, how many hours worked? _____
DATE DISABILITY CAUSED LOST TIME (MM/DD/YY)	DATE RETURNED TO WORK (MM/DD/YY)	Is illness or injury due to occupational causes? ☐ No ☐ Yes Do you have provincial health coverage? ☐ No ☐ Yes Job title: _____ Current hourly wage: $ _____

Has claim been filed with EI Sickness? ☐ No ☐ Yes

Has a claim been filed with the Worker's Compensation Board? ☐ No Yes – If Yes, provide Claim No: _____

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 (including CPP or Bricklayers pension benefits)? ☐ 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.

IN CASE OF ACCIDENT

DATE OF ACCIDENT (MM/DD/YY)	Where did the accident occur? (i.e. Home, School, Job Site, Other-specify)
How did the accident occur?	What was the claimant doing at the time of the accident?
Nature of injuries – Specify	

I hereby authorize any healthcare provider, my plan administrator, insurance companies, other organizations, or benefit service providers working with Manulife Financial and Homewood Health Inc., to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount. I agree that a facsimile copy or photo copy is to be considered effective as an original, signed copy.

(MM/DD/YY)

SIGNATURE OF MEMBER DATE

FAS

Phone (780) 452-5161

Please return original form to:
Funds Administrative Service Inc.
10154 – 108 Street, NW, Edmonton, AB T5J 1L3
Toll free: 1 (800) 770-2998

Fax (780) 452-5388

Patient Name: _____ (LAST, FIRST) _____ **ATTENDING PHYSICIAN'S STATEMENT**

Diagnosis _____

_____

Secondary/additional conditions or complications which affect duration of absence from work _____

_____

Occupational illness/injury ☐ No ☐ Yes

If yes, date of event _____ (MM/DD/YY) _____

Automobile accident ☐ No ☐ Yes

If yes, date of event _____ (MM/DD/YY) _____

To the best of your knowledge:

Indicate when the symptoms first appeared or accident happened: _____

Has patient had same or similar condition in the past? ☐ No ☐ Yes, please state when and describe _____

_____

_____

Date of first and all subsequent visits during present period of absence from work _____ (MM/DD/YY) _____

_____

Hospitalization

Date of admittance _____ (MM/DD/YY) _____ Date of discharge _____ (MM/DD/YY) _____ Institution Name _____

If surgery was performed please provide date and description of surgery

Date _____ (MM/DD/YY) _____ Description _____

Treatment (drug, dosage, physiotherapy, other): _____

_____

How does present condition affect patient's ability to work (for example, restrictions, limitations, proposed surgery, etc.) _____

_____

Were you actively supervising this patient's care during the full period? ☐ No, comment in remark _____

☐ Yes, state frequency of visits ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

If patient was referred to you, provide the name of referring physician _____

If you have referred patient to a specialist, provide name of physician and date of appointment

Name_____ Specialty _____ Scheduled appointment date _____ (MM/DD/YY) _____

Indicate period patient has been unable to work at own occupation as a result of present condition: _____ (MM/DD/YY) _____

Please indicate the approximate date this patient will be fit to return to work. If the date is unknown, please estimate the number of weeks before a possible return. Approximate return to work date_____ (MM/DD/YY) _____ Weeks until possible return _____

Is patient fit for trial return to work on part-time or modified basis? ☐ No ☐ Yes, indicate date: _____ (MM/DD/YY) _____

Is patient a suitable candidate for vocational rehabilitation program? ☐ No ☐ Yes

Remarks – Please provide comments and further details which you feel would be helpful. _____

_____

Do you believe patient is competent to endorse cheques and direct the use of the proceeds thereof? ☐ No ☐ Yes ☐ Unknown

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone #	Fax #	
Signature	Date Signed (MM/DD/YY)	

PLEASE RETURN ORIGINAL FORM TO FUNDS ADMINISTRATIVE SERVICE INC.

10154 – 108 Street, NW, Edmonton, AB T5J 1L3