

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Phone: 604 419-8040 Toll-free: 1 888-275-4672 Fax: 604 419-8055

**i** Notice of claim must be given no later than 20 days following the first day of illness or accident, and proof submitted within 90 days. Short Term Disability Benefits are self-insured by the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan. Have the attending physician complete the back of this form and then return it to your employer.

**PART 1 — EMPLOYEE'S STATEMENT**

Name		Address		City/province/postal code
Job classification or title		<input type="checkbox"/> Permanent address <input type="checkbox"/> 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 (mm-dd-yyyy)	Date of first treatment (mm-dd-yyyy)	2. Physician's name and address		
Is claim being made for WorkSafeBC? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Nature of sickness or injury		Date you returned to work (mm-dd-yyyy)	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)		
Are you in receipt of benefits from the IWA Forest Industry Pension Plan? <input type="checkbox"/> Yes   \$ _____ per month <input type="checkbox"/> No				

**PART 2 — EMPLOYEE'S CONSENT AND DECLARATION**

**!** **IMPORTANT: This section must be signed before submitting your claim.**

I certify that the above statements are correct and hereby authorize my physician, registered nurse practitioner, hospital, rehabilitation therapists and mental health treatment providers to give Pacific Blue Cross, FIDAS – Forest Industry Disability Adjudication Services, the Evergreen Rehabilitation Management Society, 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.

Employee's signature <b>X</b>	Date (mm-dd-yyyy)
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**PART 3 — EMPLOYER'S STATEMENT**

Group number <b>008942</b>	Name of Employer	Division	Sub Division	Phone #
Employee's name	Identity number/Social Insurance Number	Job classification	Date of birth (mm-dd-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> 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 (mm-dd-yyyy)	At the start of disability, the employee was:			
Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Working full time (with regular days off) Circle days off if employee works alternative shifts:   Sun   Mon   Tue   Wed   Thu   Fri   Sat			
If yes, date of return (mm-dd-yyyy)	<input type="checkbox"/> Laid off work	Date layoff commenced (mm-dd-yyyy)	Number of months coverage entitlement due to seniority	
Is this claim one which might come under WorkSafe BC or Occupational Disease Regulation? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> On leave of absence	From (mm-dd-yyyy)	To (mm-dd-yyyy)	
		Reason		
If Yes, attach copies of relevant WorkSafeBC correspondence.				
Have you any reason to question the validity of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, state reason(s)				
Is leave for extended vacation or apprenticeship training? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> On vacation with pay		From (mm-dd-yyyy)	To (mm-dd-yyyy)	

**PART 4 — EMPLOYER'S CONSENT AND DECLARATION**

I certify that the above statements are correct.

Employee's signature <b>X</b>	Employer's name (please print)	Email	Date (mm-dd-yyyy)
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**PART 1 — 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of studies (mm-dd-yyyy)	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 (mm-dd-yyyy)	Date of last treatment (mm-dd-yyyy)	If disability is related to pregnancy, expected delivery date (mm-dd-yyyy)
If hospitalized, name of hospital	Dates confined to hospital, from (mm-dd-yyyy)	To (mm-dd-yyyy)
What surgery, if any, was performed		Date of surgery (mm-dd-yyyy)
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 (mm-dd-yyyy)	To (mm-dd-yyyy)
Approximately when should patient be able to return to work?	Date (mm-dd-yyyy)	Or number of weeks

Prognosis

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

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**PART 2 — PHYSICIAN'S AUTHORIZATION**

I certify that the above statements are correct.

Physician's name (please print)	Specialty	MSC number	Phone number (10 digits)	
Address		City	Province	Postal code
Physician's signature <b>X</b>		Date (mm-dd-yyyy)		

**PART 3 — PATIENT'S AUTHORIZATION**

I hereby authorize the release to Pacific Blue Cross, FIDAS – Forest Industry Disability Adjudication Services, the Evergreen Rehabilitation Management Society, the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan and the Trustees of the IWA Forest Industry LTD Plan, any additional information requested with respect to this claim.

Patient's signature <b>X</b>	Date (mm-dd-yyyy)
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