PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

CLAIM FOR SHORT TERM DISABILTY BENEFITS USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

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

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. 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		☐ 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 (mm-dd-yyyy)	Date of first treatment (mm-dd-yyyy)	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 (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? ☐ Yes $ _____ per month ☐ 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 **X**	Date (mm-dd-yyyy)

PART 3 — EMPLOYER'S STATEMENT

Group number 008943	Name of Employer		Division	Sub Division	Phone #
Employee's name	Identity number/Social Insurance Number	Job classification		Date of birth (mm-dd-yyyy)	☐ 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 (mm-dd-yyyy)

Has employee returned to work?
☐ Yes ☐ No

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

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 (mm-dd-yyyy)	Number of months coverage entitlement due to seniority
☐ On leave of absence	From (mm-dd-yyyy)	To (mm-dd-yyyy)

Reason

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

☐ 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.

Employer's signature **X**	Employer's name (please print)	Email	Date (mm-dd-yyyy)

0572.004 50-60-120 10/20 CUPE 1816

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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? ☐ Yes ☐ 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

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

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
X | 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
X | Date (mm-dd-yyyy)