

B.C. Marine Industry Employee Health Benefit Plan

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Registration No.

WEEKLY INCOME BENEFITS CLAIM

(Claim must be filed within 30 days of becoming disabled.)

Notice to Employee:

Employer to complete appropriate section.
 Doctor to complete Attending Physician's Statement on reverse.

***Employee MUST sign on both sides of form where indicated.**

If applicable under the terms of your contract, you will be required to make application for Employment Insurance sick benefits.

1. Member Last Name _____ First Name _____

2. Member Address _____

3. City	4. Province	5. Postal Code	6. Telephone ()
7. Social Insurance Number	8. Date of Birth (yr/mo/day)	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other

11. Date last worked	12. When did you become totally disabled (unable to work) Date _____ Time _____ A.M./P.M.	13. If hospitalized, give name of hospital
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14. Dates confined to hospital IN _____ OUT _____	15. If returned to work, give date	16. If not, give date you expect to return to work
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17. Name of attending physician (please print)	18. Doctor's address
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19. Nature of disability _____

20. Accident Information — Complete only if claim is a result of injuries sustained in an accident.			
Date of Accident	Time of Accident at _____ A.M. P.M.	Was work being done for an employer at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not at work, where did accident happen?

21. Describe how accident happened _____

22. Are you receiving Employment Insurance Benefits? Yes No
 If Yes, for what amount? _____
 For what period? _____

23. Have you been self-employed or employed elsewhere during this period of disability? If "YES", explain.

24. Are you entitled to any Disability Income Benefits provided by a government agency? Yes No
 25. Are you entitled to any Disability Income under any other plan of group insurance? Yes No

26. If "YES", give policy number, name and address of the organization providing such benefits:

I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley & Associates Ltd. any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

Member Signature _____ Date _____

*** (Both must be signed before claim can be assessed)**

TO BE COMPLETED BY EMPLOYER

Name of employer	Group #
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Address	Union affiliation (if applicable)
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Date last worked and number of hours worked	Has employee been laid off? (if so, when)	Has employee returned to work? (if so, when)	Has employment been terminated? (if so, when)
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Occupation:	Is disability due to occupational sickness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has claim been filed with Workers' Compensation Board? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, date filed)
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Describe job duties fully: _____

What was the rate of earnings for which the Member was covered on date last worked? _____ W M Y

On what date did this rate first become effective? _____ day/month/year To what date (inclusive) was Member last paid? _____ day/month/year

What remuneration, if any, does the Member now receive from you? \$ _____ How long will this remuneration continue? _____ day/month/year

Amount of Weekly Income benefits per week for which the Member was covered on the date last worked \$ _____

Signed (Employers Representative)	Date	Remarks:
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PATIENT AUTHORIZATION

Name (PLEASE PRINT)

DATE OF BIRTH		
Year	Month	Day
DATE		
Year	Month	Day

I hereby authorize the release, to D.A. Townley & Associates Ltd., my insurer, and my policyholder, of any information required in connection with this claim. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

* PATIENT'S SIGNATURE _____

(This must be signed before claim is assessed.)

ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

1. Diagnosis of present condition

(a) Primary

(b) Additional conditions or complications which might affect duration of absence from work.

2. To the best of your knowledge

(a) indicate when symptoms first appeared or accident happened

Year	Month	Day

(b) has patient had same or similar condition Yes No If "Yes", please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown

4. If patient is/was pregnant, indicate due date or date of confinement.

Year	Month	Day

5. Date of hospital admission

Year	Month	Day

Date of discharge

Year	Month	Day

6. Nature of treatment (eg. date and type of surgery, treatment including medication, dosage and frequency)

7. (a) If patient was referred to you, give name of referring physician

(b) If you have referred patient to a specialist, give name(s) of physicians and provide a copy of consultation reports.

8. (a) Date of first and all subsequent visits during present period of absence from work (year, month, day)

(b) Were you actively supervising this patient's care during the full period?

No If "No", please comment in remarks

Yes If "Yes", state frequency

Weekly

Monthly

Other (specify)

9. (a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition

FROM

Year	Month	Day

TO: (inclusive)

Year	Month	Day

(b) If still unable to work, give approximate date when patient should be able to return or the estimated number of weeks before possible return

Year	Month	Day

10. (a) How does present condition affect patient's ability to work? (eg. restrictions, limitations, proposed surgery etc.)

(b) Is patient fit for trial return to work on part-time or modified basis?

Yes No

If "Yes", indicate date

Year	Month	Day

(c) Is patient a suitable candidate for a vocational rehabilitation program? Yes No

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (Print)		Specialty (Print)	Physician's Stamp Here
Telephone Number ()	Signature	Date (yr/mo/day)	

Any charge for completing this form is the patient's responsibility.