



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

MEMBER INFORMATION (TO BE COMPLETED BY MEMBER)				
LOCAL UNION		POLICY # 6128		
LAST NAME		FIRST NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		If no, how many hours worked? _____		
		Is illness or injury due to occupational causes? <input type="checkbox"/> No <input type="checkbox"/> Yes		
DATE DISABILITY CAUSED LOST TIME (MM/DD/YY)	DATE RETURNED TO WORK (MM/DD/YY)	Do you have provincial health coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		Job title: _____		
		Current hourly wage: \$ _____ Numbers of Hours Worked Per Week _____		
Have you or will you apply for Accident Benefits with your Auto Insurance Carrier?		<input type="checkbox"/> No <input type="checkbox"/> Yes		
Have you (or will you) applied/apply for any benefits from any other sources?		<input type="checkbox"/> No <input type="checkbox"/> 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.				

TO BE COMPLETED BY MEMBER	
1. Reason for leaving work (check one): <input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Strike <input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Regular Layoff <input type="checkbox"/> Dismissed <input type="checkbox"/> Quit <input type="checkbox"/> Retired	
2. Is condition due to work related accident or illness? <input type="checkbox"/> No <input type="checkbox"/> Yes Has a claim been filed with WCB? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, claim number _____ Are you presently receiving Workers' Compensation Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If work related but no claim filed, please provide reason _____ _____	
3. Has a claim been filed with Employment Insurance for regular EI benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you presently receiving EI regular benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes Has a claim been filed with EI for Sickness and Accident benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you presently receiving EI Sickness and Accident benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide a copy of all your EI Sickness and Accident paystubs.	
4. Plan Member's current basic weekly earnings \$ _____ <input type="checkbox"/> Tax Exempt <input type="checkbox"/> Basic <input type="checkbox"/> Other	
5. Do you expect to return to work? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give approximate date _____ (dd/mm/yy)	
6. Is modified or part time work available? <input type="checkbox"/> No <input type="checkbox"/> Yes	
7. Prior to the last day worked, were you currently working (please check one of the following): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Full time on modified duties <input type="checkbox"/> Part time on modified duties	
8. If modified, from what date _____ Was it a result of work related accident/illness? <input type="checkbox"/> No <input type="checkbox"/> Yes (dd/mm/yy)	



9. Please provide a brief job description _____

10. If disability benefits are payable from any other source, please identify and state amount. \$ _____ Source: _____
11. Please furnish any other information you believe is pertinent to this claim. _____

12. On what date were you first unable to work due to illness? _____ at A.M. P.M.
 (dd/mm/yy)
13. On what date do you expect to return to work? _____
 (dd/mm/yy)
14. Have you discussed modified duties or a part time return to work with your physician? No Yes
 What was his/her response? _____
15. Is your disability due to a car or motor vehicle accident? No Yes If yes, please answer the following questions:
 When did it happen? _____ at _____ A.M. P.M.
 Where did it happen? at home at work other (name place) _____
 How did it happen? _____

 Was the car or motor vehicle accident reported to the police? No Yes
 If yes please provide name of police officer and address of detachment and provide a copy of police report _____

 Are you taking action against a third party? No Yes If yes, provide your lawyer's name and address.
 Name: _____ Address: _____
 List names and addresses of physicians (other than the physician who completed the claim form) who have treated you in connection with this
 condition _____
16. Have you been hospitalized for this condition? No Yes
 If yes, date hospitalized _____ to _____
 (dd/mm/yy) (dd/mm/yy)

RECOVERY COSTS FROM A THIRD PARTY (YOU MUST ANSWER EACH QUESTION)


(A) If this claim is as a result of an illness/injury you must complete the following.

(See "Recovery Cost from a Third Party" section on the enclosed Weekly Disability Benefit information sheet)

I, _____ do hereby state that, as a result of my disability, a **claim has been made, or should a claim be made, against a Third Party.**

I understand that any payment made to me by the Trust Fund as a result of this disability is considered "an advance".

In consideration of receiving benefits from the Plan I, _____, **agree to fully reimburse the Plan from any monies I receive from any third party, insurer, or other source whatsoever arising out of the matter for which I received the benefits and that I fully understand the reimbursement shall be free of any deductions for any expense I may have incurred to recover same.**

Required for all illness/injury 

Signature: _____

(B) Are you **receiving** or have you **applied** for Disability Benefits from any source below:

(Place check mark below)

CANADA PENSION PLAN	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Neither
WORKERS' COMPENSATION	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Neither
EMPLOYMENT INSURANCE	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Neither
RETIREMENT / DISABILITY PENSION	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Neither



If you have indicated that you are "receiving" to any – please provide the following information:

Name of Program:	Payment Amount:	Payment Dates:	Began	Ended

If you have indicated that you have "applied" to any of the above please provide **name of program** and **date applied**:

Name of Program:	Date Applied:

Please provide copies of any correspondence from CPP, EI or WCB

(C) Have you any other source of income not mentioned above? NO YES

If yes, provide details below:

DECLARATION AND AUTHORIZATION

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize Funds Administrative Service Inc. (FAS), Manulife, Homewood Health Inc. and the Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, FAS, Manulife Homewood Health Inc. and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where FAS, Manulife, Homewood Health Inc. and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with FAS, Manulife, Homewood Health Inc. or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize FAS, Manulife, Homewood Health Inc. or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for FAS, Manulife, Homewood Health Inc. or the Trust Fund. A copy of this authorization shall be valid as the original.

(MM/DD/YY)

SIGNATURE OF MEMBER

DATE



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



Please provide all information and documentation as requested on this form so that we can better understand the extent of your patient's condition and the resulting impairments. The information provided will form the basis upon which entitlement to benefits will be assessed

**** COMPLETION OF THIS FORM AND SUBSEQUENT FORMS IS THE RESPONSIBILITY OF THE CLAIMANT ****

All information on this form should be clearly printed

PATIENT INFORMATION				
LOCAL UNION			POLICY # 6128	
LAST NAME	FIRST NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MM/DD/YY)	
ADDRESS			CERTIFICATE / SIN	
CITY	PROVINCE	POSTAL CODE	PHONE	
PHYSICIAN INFORMATION				
LAST NAME		FIRST NAME		
ADDRESS				
CITY	PROVINCE	POSTAL CODE	SPECIALTY	
PHONE	FAX		EMAIL ADDRESS	
DIAGNOSIS OF PRESENT CONDITION (PLEASE PRINT)				
1.				
a) Primary _____				
b) DSM IV terminology codes:				
Axis I _____				
Axis II _____				
Axis III _____				
Axis IV _____				
Axis V _____				
c) Secondary _____				
d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown				
e) Please enclose copies of the following documents in support of the stated diagnosis:				
<input type="checkbox"/> consultation notes <input type="checkbox"/> test/investigation reports <input type="checkbox"/> assessment reports				
<input type="checkbox"/> clinical notes <input type="checkbox"/> psychological testing reports <input type="checkbox"/> hospital admission history				
<input type="checkbox"/> operative reports <input type="checkbox"/> other _____				
2. To the best of your knowledge, indicate when symptom(s) first appeared _____ (dd/mm/yy)				
(a) Patient has been unable to perform his/her duties since _____ (dd/mm/yy)				
3. Has the patient had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If yes, please state when and describe.				

4. Please state all current symptoms on which your diagnosis is based

5. Current Impairments

(i) Physical Impairment - please check:

- Class 1 (no impairment – capable of strenuous physical activity)
- Class 2 (slight limitation – capable of moderate activity)
- Class 3 (moderate limitation – capable of light activity)
- Class 4 (marked limitation – capable of minimal activity)
- Class 5 (severe limitation – incapable of minimal activity)

(ii) Is your patient:

- Ambulatory
- House Confined
- Bed Confined
- Hospital Confined

(iii) Is your patient capable of:

- Lifting _____ kgs/lbs
- Sitting _____
- Walking _____
- Squatting _____
- Standing _____
- Bending _____
- Climbing _____

(iv) Does your patient require assistive devices? If yes, please specify _____

(v) Psychiatric Impairments – please check:

- Class 1 (able to function under stress and engage in interpersonal relationships – no limitations)
- Class 2 (able to function in most stress situations and engage in most interpersonal relationships – slight limitation)
- Class 3 (able to engage in only limited stress situations and limited interpersonal relationships – moderate limitation)
- Class 4 (unable to engage in stress situations or engage in interpersonal relationships – marked limitation)
- Class 5 (patient has significant loss of psychological and social abilities – severe limitation)

(vi) How does your patient's psychiatric disorder affect his/her ability to work?

6. Please provide specific restrictions and limitations.

7. Other factors influencing condition (for example – work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional license etc.) _____

8. Is there an alcohol or substance abuse problem? No Yes If yes, please specify treatment center and program details.

9. Current medications. Please specify names of drugs, dosages, start dates and duration.

Response to treatment: _____

10. Other treatment – for example, physiotherapy, counseling, day treatment programs. Please specify type, frequency and full name of facility.

Response to treatment:

11. Dates Hospitalized (recent) Admission Date _____ Discharge Date _____
(dd/mm/yy) (dd/mm/yy)

Institution: _____ Reason: _____

12. Compliance: Is your patient following the recommended treatment program? No Yes If no, please explain:

Please state frequency of visits: weekly monthly other, please specify _____

Date of first visit and all subsequent visits during present period of absence from work:

Please provide details of any proposed treatment plan including any recommended surgery.

Have you referred your patient to any other physician? No Yes If yes, please provide the full name and specialty

13. What do you understand your patient's occupation to be? _____

Are you familiar with the requirements of your patient's occupation? No Yes If yes, please comment

Has your patient expressed a desire to return to work? No Yes If yes, please comment

What are your patient's specific work restrictions / limitations? _____

Please confirm the date your patient was/will be capable of returning to the workforce (dd/mm/yy)

To Own Occupation _____ To any other occupation _____

14. Is your patient competent to endorse cheques and direct the use of the proceeds? No Yes

If no, from what date? _____ (dd/mm/yy)

15. Has your patient's professional license, certification, driver's or other license been Restricted Suspended Revoked

If yes, date (dd/mm/yy) _____ Type of license _____ Class _____

16. Additional Remarks:

17. Have you provided medical information on your patient's behalf for other benefits? If yes, please provide the full name of the company

PHYSICIANS DECLARATION

I declare that the information on this statement is true to the best of my knowledge.

Physician's Signature (in full)

Date: (dd/mm/yy)

Stamp:



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ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENT

MEMBER INFORMATION				
LOCAL UNION		POLICY # 6128		
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ADDRESS			CERTIFICATE / SIN	
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TO: Funds Administrative Service Inc. on behalf of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan

AND TO: The Member

IN CONSIDERATION of Funds Administrative Service Inc. (on behalf of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan) agreeing to pay me a weekly disability benefit, I agree that if I am subsequently found not to be entitled to receive a weekly benefit or to have received an overpayment of the benefit that I will, on demand of Funds Administrative Service Inc., repay to Funds Administrative Service Inc. the amount of such overpayment.

I acknowledge that an overpayment to me may result if, for example, I am not eligible under the Rules of the Policy for a weekly disability benefit. Additionally, if I am entitled to benefits under Workers' Compensation or a sickness or regular benefit from Employment Insurance, or SGI Accidental Benefits claim, I would be excluded from receiving weekly disability under this Plan. These examples would exclude payments received from an individual disability policy. I acknowledge that the foregoing are examples of why I may not be entitled to receive a full weekly disability benefit from Funds Administrative Service Inc. and that there may be other reasons why I am not entitled to receive from Funds Administrative Service Inc. that full benefit.

Accordingly, I agree to repay the amount of such overpayment upon demand by Funds Administrative Service Inc.

DATED at the City of _____, in the Province of _____,
this _____ day of _____, 20____.

SIGNED IN THE PRESENCE OF:

Signature of Witness

Signature of Member

Name

Name

Address & Phone Number



CONSENT TO RELEASE

MEMBER INFORMATION			
LOCAL UNION		POLICY # 6128	
LAST NAME	FIRST NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
CITY	PROVINCE	POSTAL CODE	PHONE

I hereby expressly consent, authorize and direct:

- o Workers' Compensation Board
- o Employment Insurance
- o Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan
- o Medical Practitioners I have attended
- o A center for treatment of addictions that I have attended or will attend

- o to disclose any knowledge and information requested by the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan, in respect to my Weekly Disability Benefit Claim.

DECLARATION AND AUTHORIZATION		
<p>I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.</p> <p>I authorize Funds Administrative Service Inc. (FAS), Manulife, Homewood Health Inc. and the Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, FAS, Manulife Homewood Health Inc. and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where FAS, Manulife, Homewood Health Inc. and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with FAS, Manulife, Homewood Health Inc. or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize FAS, Manulife, Homewood Health Inc. or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.</p> <p>I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.</p> <p>I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for FAS, Manulife, Homewood Health Inc. or the Trust Fund. A copy of this authorization shall be valid as the original.</p>		
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<table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">SIGNATURE OF MEMBER</td> <td style="width: 40%;">DATE</td> </tr> </table>	SIGNATURE OF MEMBER	DATE
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