Weekly Indemnity Claim Form

Group Claims Department

Insured Member – Complete this section. Please print clearly.

1.	Name of Union **Sheet Metal Workers Local 285**					
2.	Group Insurance Policy Number	Occupation	Identification Number			
3.	Name	Date Of Birth (dd/mm/yyyy)				
4.	Street Address					
	City/Town	Province	Postal Code			
5.	On what date were you first disabled and unable to work (dd/mm/yy) ☐ AM ☐ PM	On what date do you expect to return to work (dd/mm/yy)				
6.	Is disability due To an accident ☐ Yes ☐ No	If "Yes", please answer The following question.	When did it happen? (dd/mm/yyyy)	Time	:	☐ AM ☐ PM
	Where did it happen: ☐ at home ☐ at work	☐ elsewhere (name place)	How did it happen?			
7.	On what date were you first treated by a physician for this disability?	(dd/mm/yyyy)				
8.	List name and address of physicians who have treated you in connection with this disability.					
9.	Have you been hospitalized In connection with this disability ☐ Yes ☐ No	If "Yes", please indicate name of hospital:	Dates Hospitalized: From: (dd/mm/yyyy)	To: (dd/mm/yyyy)		
10.	Are disability benefits payable from Any other source as the result of This sickness or injury? ☐ Yes ☐ No	If "Yes", give name of source:				
11.	The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to and use by Global Benefits of any medical or other information that may be required to establish the validity of this claim and further empower said Company to disclose any personal or claim information needed to medical case review or study. A photocopy of this release shall be as valid as the original.					

Date | Insured Member's Signature

Business Agent – complete this section. Please print clearly.

1.	On what date did this insured Member last work (dd/mm/yyyy)					Number of Hours	
2.	What was the reason for leaving work? (check appropriate box)	☐ Disability	☐ Dismissed	☐ Temporary Layoff	☐ Strike	☐ Quit	☐ Retired
3.	If insured member became disabled while on layoff, what was the date he/she was recalled and was unable to report to work? (dd/mm/yyyy)						
4.	Is this disability due to an Occupational sickness or injury? ☐ Yes ☐ No	If "Yes", has a claim been made for Workers Compensation Benefits ☐ Yes ☐ No					
5.	Do you expect insured member To return to work? ☐ Yes ☐ No	I "Yes", give expected date of return (dd/mm/yyyy)					

Date | **Signature** | **Title**

Member – send completed forms to:

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8
Phone 416-635-6000 ✂ Fax 416-635-6464

GLOBAL BENEFITS

Attending Physician's Statement - Please return completed form to your patient

1.	Patient's Name			Age	
2.	Is condition due to injury or sickness arising Out of patient's employment?	☐ Yes	☐ No	☐ Unknown	
3.	Diagnosis of present condition Primary (a) Secondary (If applicable) (b) If appropriate – Additional conditions which might effect the duration of disability				
4.	To the best of my knowledge (a) Symptoms first appeared or accident happened		Month	Day	Year
	(b) Patient has had same or similar condition	☐ Yes	☐ No	If "Yes", state when and describe	
5.	Date of hospital in-patient admission	Month	Day	Year	
	Date of discharge	Month	Day	Year	
6.	If surgery performed, describe, Date:	7.	If referred to you, give name of referring physician		
8.	(a) Date of first visit for present period of disability		Month	Day	Year
	(c) Date of latest attendance		Month	Day	Year
	(d) Were you actively supervising this patient's care during the full period?	☐ No If "No", please comment in question 12. ☐ Yes If "Yes", state frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify)			
9.	If condition is due to pregnancy, what is (or was) the expected date of confinement?		Month	Day	Year
10.	(a) To the best of my knowledge, this patient has been Totally Disabled) (Unable to work)	From To Inclusive	Month Month	Day Day	Year Year
	(b) If still disabled, give approximate date when patient should be able to return to work.		Month	Day	Year
	(c) Or, if indefinite, the estimated number of weeks before such return				Weeks
11.	How long was or will patient by Partially Disabled? (able to work part-time at own occupation)	From To Inclusive	Month Month	Day Day	Year Year
12.	How does present condition affect patient's ability to work?				
	Additional remarks				

Physician's Name (please print)	Address	
Telephone Number (Include area code)	Physician's Signature	Date

I hereby authorize the release to my insurer and my policyholder of any information requested in respect of this claim.

Telephone Number (include area code)	Patient's Signature	Date

The patient is responsible for securing this form and for charges made for its completion.