THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

WEEKLY DISABILITY BENEFIT CLAIM

INSTRUCTIONS: 1. Complete Part 1, and sign form where indicated for Parts 1 and 2.
2. Have your doctor complete Part 2 on the back of this form.
3. Return the completed form to:

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
16214 - 118 AVENUE, EDMONTON, ALBERTA T5V 1M6
TELEPHONE: 780-452-1331

4. Completed claims must be submitted within 60 days of the date on which total disability commenced. Late filed claims will be declined.

PART 1 - MEMBER'S STATEMENT

1. NAME

2. SOCIAL INSURANCE NUMBER

3. ADDRESS

4. DATE OF BIRTH ____ | ____ | ____ (YEAR | MONTH | DAY) SEX ☐ MALE ☐ FEMALE

CITY PROVINCE POSTAL CODE

5. HOME TELEPHONE NUMBER

6. NAME OF LAST OR CURRENT EMPLOYER

7.
A. DATE EMPLOYMENT COMMENCED ____ | ____ | ____ (YEAR | MONTH | DAY)

8. REASON FOR LEAVING: LAYOFF ☐ ILLNESS ☐ ACCIDENT ☐ OTHER ☐ _____

B. DATE LAST WORKED ____ | ____ | ____ (YEAR | MONTH | DAY)

9. BRIEF DESCRIPTION OF JOB DUTIES

_____

_____

10. DATE TOTAL DISABILITY COMMENCED ____ | ____ | ____ (YEAR | MONTH | DAY)

11. DATE OF EXPECTED RETURN TO WORK ____ | ____ | ____ (YEAR | MONTH | DAY)

12. IF DISABILITY IS DUE TO AN ACCIDENT, PLEASE INDICATE: (A) DATE AND TIME OF ACCIDENT

____ | ____ | ____ (YEAR | MONTH | DAY) AT ____ AM ☐ PM ☐

(B) IS THE DISABILITY A RESULT OF A MOTOR VEHICLE ACCIDENT? YES ☐ NO ☐

(C) DID ACCIDENT OCCUR AT WORK? YES ☐ NO ☐

(D) DETAILED DESCRIPTION OF ACCIDENT AND HOW IT HAPPENED (ATTACH PAGE IF MORE SPACE REQUIRED) _____

_____

13. ARE YOU NOW: HOUSE CONFINED ☐ BED CONFINED ☐ HOSPITAL CONFINED ☐ AMBULATORY ☐ WORKING ☐

14. IF CONFINED TO HOSPITAL: NAME OF HOSPITAL _____

DATE AND TIME ADMITTED ____ | ____ | ____ (YEAR | MONTH | DAY) AT ____ AM ☐ PM ☐

DATE AND TIME DISCHARGED ____ | ____ | ____ (YEAR | MONTH | DAY) AT ____ AM ☐ PM ☐

15. ARE DISABILITY BENEFITS PAYABLE FROM ANY OTHER SOURCE AS THE RESULT OF THIS SICKNESS OR INJURY? YES ☐ NO ☐

IF "YES", GIVE NAME OF SOURCE AND DETAILS. _____

16. STATE BRIEFLY DAILY ROUTINE SINCE LEAVING WORK. MENTION ANY LIGHT TASKS YOU ARE ABLE TO PERFORM.

_____

_____

17. NAMES AND ADDRESSES OF ALL DOCTORS CONSULTED DURING PRESENT DISABILITY.

_____

_____

18. I hereby warrant that the information contained on this form is true and complete to the best of my knowledge and belief. I authorize use of my Social Insurance Number for claim identification purposes only. I understand that the information I provide will be protected pursuant to the relevant legislation. I authorize the Board of Trustees, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited. I acknowledge that benefits under this Plan are integrated with Employment Insurance (E.I.) Sickness Benefits, and I must provide documentation from E.I. if I have exhausted or do not qualify for E.I. Sickness Benefits. I further acknowledge that no benefit is payable for any period during which I engage in work at any occupation for remuneration or profit (other than as part of an approved rehabilitation program).

DATE _____ 20 _____ SIGNATURE OF MEMBER _____

THIS BENEFIT IS NOT INSURED. DISABILITY BENEFITS ARE FUNDED SOLELY BY THE ASSETS OF THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND.

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. PATIENT'S NAME

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING: (A) OUT OF PATIENT'S EMPLOYMENT YES ☐ NO ☐ UNKNOWN ☐
   (B) FROM A MOTOR VEHICLE ACCIDENT YES ☐ NO ☐

3. DIAGNOSIS OR PRESENT CONDITION
   (A) PRIMARY
   (B) SECONDARY (IF APPLICABLE) OR ADDITIONAL CONDITIONS WHICH MIGHT AFFECT DURATION OF DISABILITY

4. TO THE BEST OF MY KNOWLEDGE
   (A) SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED ____ YEAR ____ MONTH ____ DAY
   (B) PATIENT HAS HAD SAME OR SIMILAR CONDITION YES ☐ NO ☐
   (C) IF "YES", STATE WHEN AND DESCRIBE _____

5. DATE OF HOSPITAL IN-PATIENT ADMISSION ____ YEAR ____ MONTH ____ DAY
   DATE OF HOSPITAL OUT-PATIENT ADMISSION ____ YEAR ____ MONTH ____ DAY
   DATE OF HOSPITAL DISCHARGE ____ YEAR ____ MONTH ____ DAY
   ____ YEAR ____ MONTH ____ DAY

6. IF SURGERY WAS PERFORMED, ENTER DATE ____ YEAR ____ MONTH ____ DAY
   WAS GENERAL ANAESTHETIC ADMINISTERED? ____ YEAR ____ MONTH ____ DAY
   DESCRIPTION _____

7. IF REFERRED TO YOU, GIVE NAME OF REFERRING PHYSICIAN

8. (A) DATE OF FIRST VISIT FOR PRESENT PERIOD OF DISABILITY ____ YEAR ____ MONTH ____ DAY
   (B) DATE OF LATEST ATTENDANCE ____ YEAR ____ MONTH ____ DAY
   (C) WERE YOU ACTIVELY SUPERVISING THIS PATIENT'S CARE DURING THE FULL REPORT PERIOD? YES ☐ NO ☐
   IF "NO", PLEASE EXPLAIN _____
   IF "YES", STATE FREQUENCY OF VISITS WEEKLY ☐ MONTHLY ☐ OTHER ☐ (SPECIFY) _____
   NATURE OF TREATMENT _____

9. IF CONDITION IS DUE TO PREGNANCY, WHAT IS (OR WAS) THE EXPECTED DATE OF CONFINEMENT ____ YEAR ____ MONTH ____ DAY

10. HOW DOES PRESENT CONDITION AFFECT PATIENT'S ABILITY TO WORK?

11. (A) TO THE BEST OF MY KNOWLEDGE, THE PATIENT HAS BEEN TOTALLY DISABLED (UNABLE TO WORK)
    FROM ____ YEAR ____ MONTH ____ DAY TO ____ YEAR ____ MONTH ____ DAY INCLUSIVE
    (B) IF STILL DISABLED, GIVE APPROXIMATE DATE WHEN PATIENT SHOULD BE ABLE TO RETURN TO WORK ____ YEAR ____ MONTH ____ DAY
    OR, IF INDEFINITE, THE ESTIMATED NUMBER OF ADDITIONAL WEEKS BEFORE SUCH RETURN _____ ADDITIONAL WEEKS FROM TODAY.

12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ABLE TO WORK PART-TIME AT OWN OCCUPATION)
    FROM ____ YEAR ____ MONTH ____ DAY TO ____ YEAR ____ MONTH ____ DAY INCLUSIVE

PHYSICIAN'S NAME (PRINT)

ADDRESS

TELEPHONE NUMBER

SIGNED THIS _____ DAY OF _____ 20 _____ SIGNATURE OF PHYSICIAN (STAMP NOT ACCEPTED)

I HEREBY AUTHORIZE THE RELEASE TO THE PLAN ADMINISTRATOR ANY INFORMATION REQUESTED IN RESPECT OF THIS CLAIM.

SIGNED THIS _____ DAY OF _____ 20 _____ SIGNATURE OF PATIENT

THIS PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION.

Return the completed form to:
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