Short Term Disability Claim Form

the benefits trust

HOW TO SUBMIT YOUR CLAIMS:

By Fax: 905-264-1123 | By Mail: The Benefits Trust, 3800 Steeles Ave. West, Suite #102W, Vaughan, Ontario, L4L 4G9

The patient is responsible for any fees related to the completion of this form.

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name		Plan Contract #	Member Certificate #
Height	Weight	Date of Birth (dd/mm/yyyy) ____________	**Last Date Worked** (dd/mm/yyyy) ____________

I hereby authorize the release of medical and health information in my file to The Benefits Trust and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form.

______________________________ Plan Member/Employee Signature

____________________ Date of Consent (dd/mm/yyyy)

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Date Returned to Work or Expected Return to Work date (dd/mm/yyyy) ____________________

Primary Diagnosis: ____

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Secondary and/or Complications: ____

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If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): ____________ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) ____________	Auto accident Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) ____________
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) ____________	First date of work absence due to condition: (dd/mm/yyyy) ____________

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy) ____________ Date of discharge (dd/mm/yyyy) ____________ Institution Name ____________

If surgery was performed please provide date and description of surgery

Date (dd/mm/yyyy) ____________ Description: ____________________________

Treatment (drug, dosage, physiotherapy, other):

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____

Prognosis Please provide the prognosis for recovery:

____

____

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Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ______________________________ Treatment Provider: ______________________________________

Please describe the patient's symptoms including history, severity and frequency: ____

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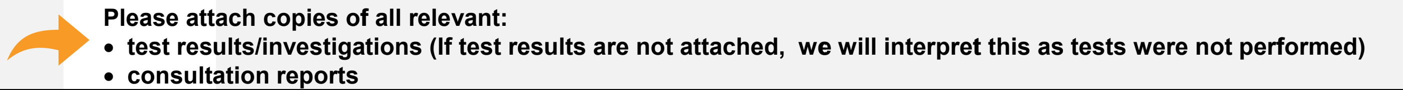
Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other_________________



Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist ______________________________ Specialty___________________________ Date of Visit _____________

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations.

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Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

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Is the patient following the recommended treatment program? Yes ☐ No ☐

Do you have concerns about the patient's ability to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

____

____

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ area code)	Fax # (+ area code)	
Signature	Date Signed (dd/mm/yyyy)	

Claims Direct Deposit Authorization Form
(Electronic Funds Transfer)

You may choose to have claims payments from The Benefits Trust deposited directly to your bank account. Explanations of benefits will be sent by email to the address provided on this form. **Please print clearly.** To set up this convenient process, complete this form and return it with a "void" cheque to The Benefits Trust.

Employee Information

Employee Name (as shown for banking purposes):

____

Employee Email: ______________________________

Employer Name: ______________________________

Contract or Group No: ________________ Certificate No: ________________

Attach "void" cheque

I authorize The Benefits Trust to deposit all future claims payments directly to the account shown on the attached "void" cheque. I understand that any change to this authorization must be submitted in writing.

Signature: ______________________________ Date: ________________

Return the completed form by mail, email, or fax with a "void" cheque. Please contact our office with questions.

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

Fax: 905-264-1123
Email: claims@thebenefitstrust.com

Phone: 905-264-8990
Toll Free: 800-487-2993

For internal use only
EFT Processed: ________________