ACCIDENT AND SICKNESS CLAIM FORM

Forward claims to: THE BENEFITS TRUST
3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9 Phone: 905-264-8990, 1-800-487-2993 Fax: 905-264-1123

Employee Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Last Name: ______________________ First Name: ______________________

Address: ______________________ Apt. # __________

City: ______________ Province: ______________ Postal Code: __________

Home Telephone: ______________________ Occupation: ______________________

Date of Birth: (Month) ________ (Day) ________ (Year) ________ S.I.N. : __________ - __________ - __________

Date of sickness / injury: (M) ________ (D) ________ (Y) ________ Where did it occur? Home ❑ Work ❑

Elsewhere: ______________________

Cause of sickness / injury: ______________________

____

I hereby certify the above statements are true and I authorize all medical practitioners who may have attended or examined me and all hospitals to furnish The Benefits Trust all information with respect to this claim. Furthermore, The Benefits Trust may use my social insurance number for identification purposes. I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. A photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Employee Signature: ______________________ Date: (M) ________ (D) ________ (Y) ________

Please inform The Benefits Trust as soon as you return to work.

Employer Information

Name of Employer: ______________________ Telephone: ______________________

Reason for absence: ______________________ Earnings at date of disability: ______________________

Was this an accident? Yes ❑ No ❑ Did this sickness or injury occur on the job? Yes ❑ No ❑

If Yes, has it been reported to Workplace Safety & Insurance Board? ______________________

If disability is due to pregnancy, has this employee received or will be receiving any maternity leave? Yes ❑ No ❑

Maternity leave to start: (M) ________ (D) ________ (Y) ________ End of leave: (M) ________ (D) ________ (Y) ________

Did disability occur during employee's vacation? Yes ❑ No ❑ If yes, specify vacation period: ______________________

Last day worked: (M) ________ (D) ________ (Y) ________

Date returned or expected to return to work: (M) ________ (D) ________ (Y) ________

Do you know any reason why this claim should not be paid? Yes ❑ No ❑

If yes, please clarify: ______________________

____

Employer Signature: ______________________ Date: (M) ______ (D) ______ (Y) ______

INFORMATION MUST BE COMPLETE OR CLAIM WILL NOT BE PROCESSED

Attending Physician's Statement

1. Patient's name: ______________________ Date of Birth: (M) ________ (D) ________ (Y) ________

2. Diagnosis and Symptomatology (Accurate diagnosis required to cause "total" or "partial" disability, and complications if any).

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3. Is this a Workplace Safety & Insurance Board case? Yes ❑ No ❑

4. a) Is the patient pregnant? Yes ❑ No ❑

   b) Is pregnancy the cause of this disability? Yes ❑ No ❑ If yes, please clarify below in item 10.

   c) Expected date of delivery: (M) ________ (D) ________ (Y) ________

5. Name of Hospital (if patient was hospitalized): Date of hospitalization: (M) ________ (D) ________ (Y) ________

   ______________________ Date of discharge: (M) ________ (D) ________ (Y) ________

6. If patient was referred to you, name of referring physician: ______________________

7. Dates of all office visits and procedure(s) performed:

   Date: (M) ________ (D) ________ (Y) ________ Procedure: ______________________

   Date: (M) ________ (D) ________ (Y) ________ Procedure: ______________________

   Anticipated physiotherapy: Yes ❑ No ❑

8. a) Date of first consultation with present condition: (M) ________ (D) ________ (Y) ________

   b) Date of first symptoms of this condition: (M) ________ (D) ________ (Y) ________

   c) Follow up appointment date: (M) ________ (D) ________ (Y) ________

9. a) This patient was totally disabled from: (M) ________ (D) ________ (Y) ________ to: (M) ________ (D) ________ (Y) ________

   b) If still disabled, indicate approximate date of return to work: (M) ________ (D) ________ (Y) ________
   (Must be specific date – may be changed later)

   c) If disability is not total, indicate date on which partial disability began: (M) ________ (D) ________ (Y) ________
   (Please try to asses whether this illness or injury is severe enough to cause **total** or **partial** disability from employee's present job)

10. Comments: ______________________

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Physician Signature: ______________________ Date: (M) ________ (D) ________ (Y) ________

Name (please print): ______________________ Telephone: ______________________

Address: ______________________

City: ______________________ Province: ______________________ Postal Code: ______________________

IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE PATIENT'S RESPONSIBILITY