ACCIDENT AND SICKNESS CLAIM FORM

the benefits trust

Forward claims to: THE BENEFITS TRUST
1453 Pelham St, Fonthill, Ontario, L0S 1E0 Phone: 905-264-8990, 1-800-487-2993 Fax: 905-264-1123

Employee Information

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss

Last Name: _____ First Name: _____

Addr es s: _____ 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? ☐ Work ☐ Pr6 n_e

Els ewh er e: _____

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).

_____

_____

_____

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) _____ Date: Procedure: _____

   (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 **tot al**or **parti al**disability from employee's present job)

10. Comments:

_____

_____

Physician Signature: _____ Date: (M) _____ (D) _____ (Y) _____

Name (please print): _____ T el ep ho ne: _____

Addr es s : _____

City: _____ Pro v inc e: _____ Postal Code: _____

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