TEAMSTERS' NATIONAL
Pension Plan • Benefit Plan

TEAMSTERS' NATIONAL BENEFIT PLAN
WEEKLY INDEMNITY CLAIM FORM

2020 REVISION

Please have this form completed in the following order:

INSTRUCTIONS TO EMPLOYEE

1. **Complete and sign the "Employee's Statement".**
2. **Have Employer complete "Employer's Statement".**
3. **Have your doctor complete the "Attending Physician's Statement" on the reverse of the form.**
4. **Send form to:** Teamsters' National Benefit Plan, 1610 Kebet Way, Port Coquitlam, BC V3C 5W9
   Phone: 604-552-2650 Fax: 604-552-2653 TF: 1-888-478-8111 Email: benefits.pensions@teamstersbenefits.ca

EMPLOYEE'S STATEMENT: (Complete in FULL)

FOR COVID-19 DIAGNOSIS ONLY

Full name of employee:

Address:

No. Street City or Town Prov. Postal Code

Date of birth:	Height:	Weight:	Member ID Number:	Telephone Number:

Name of employer:

Your normal occupation:

1. Date accident or sickness began — Day Month Year
2. Date last worked — Day Month Year
3. Date of first treatment — Day Month Year
4. a. Was disability caused by or related to your employment? Yes ☐ No ☐
   b. Have you filed or do you intend to file a WorkSafe BC claim? Yes ☐ No ☐
   c. Have you obtained assistance from the Workers Advisors office? Yes ☐ No ☐
5. Nature of sickness or injury:
6. Physician's name and address:
7. If disability is the result of an injury:
   a. Where did accident happen?
   b. Describe the accident: (attach additional information if necessary)
   c. At what time of day did accident occur?
8. Date you returned to work or expect to return to work:
9. Are you receiving or have you applied for disability benefits from **any other source?** If yes give details under "Comments": (I.E. Employment Insurance, WorkSafe BC, ICBC) Yes ☐ No ☐
10. Are you engaged in any other occupation? Yes ☐ No ☐

Comments:

I certify that the above statements are correct. I authorize the Teamsters' National Benefit Plan "the Plan" to collect, use and disclose my personal information (including my medical information) to administer a claim for benefits from the Plan and specifically to exchange my personal information with any healthcare provider (including any physician, practitioner, independent medical examiner, hospital and clinic) and with any insurance company or other organization if that exchange is reasonably necessary to administer my claim. This authorization covers personal information the Plan receives from me and from any other person or entity such as a treating healthcare provider or insurance company. I release and hold harmless the Plan (and its employees) from any liability resulting from such collection, use or disclosure.

Date _____ Employee's Signature _____

IMPORTANT **THE INCOME TAX ACT PROVIDES THAT YOUR WEEKLY INDEMNITY BENEFITS ARE SUBJECT TO INCOME TAX. IF YOU WISH TO HAVE INCOME TAX DEDUCTED FROM YOUR BENEFITS EACH WEEK AT A RATE OF 10% OF BENEFIT, PLEASE SIGN BELOW:**

DATE _____ **EMPLOYEE'S SIGNATURE** _____

EMPLOYER'S STATEMENT

Employee's regular hourly wage rate _____

If dependent contractor, 12 month gross _____

Number of hours worked in a regular work week immediately prior to commencement of disability _____

On date of disability, was employee: Actively employed ☐ Terminated ☐

Was disability incurred in course of employment? _____

Employee type: Regular Employee - Union ☐ Regular Employee - Non-Union ☐ Dependent Contractor ☐

Normal Occupation _____

Date employee last worked _____

Laid Off ☐ Other ☐ Vacation ☐

Date employee returned to work _____

Date _____ Employer _____

Telephone _____ Authorized Signature _____

Email _____ Please Print Name _____

FOR COVID-19 ONLY

TNBP Plan Member Confirmation of COVID 19 Illness Form –APS Replacement Form

Please only complete this form if you have a clinical diagnosis of COVID-19.

In order to assist the healthcare community, the Plan will not require the Attending Physician's Statement for COVID 19.

We will, however, require confirmation of your symptoms, your test results, and any medical treatment you may have received for your condition.

Please submit your completed form via email to:

benefits.pensions@teamstersbenefits.ca

1. Please provide/circle associated symptoms:

Fever	Muscle aches
Cough	Sore throat
Decreased appetite	Shortness of breath
Runny nose	Vomiting
Nausea	Fatigue
Headache	

Other, please explain: _____

2. Please advise date you were diagnosed/tested with COVID 19

_____
day/month/year

3. Please provide name, address and phone number of medical facility where you were tested and provided with confirmation of COVID 19.

4. Are you quarantined at this time? Please circle
   a) Yes, provide date _____ b) No _____

   Please provide date quarantine period will end. _____
5. Please provide date you will be seen by a physician: _____

6. Please provide date you expect to return to work: _____

7. Are you able to work from home? Please circle: Yes No

Name _____ Signature_____Date_____