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)

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 _____

ATTENDING PHYSICIAN'S STATEMENT
Please return completed form to your patient or email directly to the Plan.

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE ONSET OF DISABILITY

DISABILITY BENEFIT

1. Patient's Name and Address

Age _____
Height _____
Weight _____

2. (a) Primary Diagnosis of Present Disabling Condition

(b) Secondary (if applicable)

3. Additional Conditions Which Affect the Duration of Disability

4. **TREATMENT**

(a) Date of patient's first visit for this disability Day _____ Month _____ Year _____

(b) Date of patient's most recent visit for this disability Day _____ Month _____ Year _____

(c) Were you actively supervising the patient's care during the full period? **Yes** _____ **No** _____ (if "No", please comment under "Remarks")

(d) Please state frequency of visits: Weekly _____ Monthly _____ Other (please specify) _____

(e) Please specify **nature of recommended treatment. If prescribed, please also include medications and dosage.** _____

_____

(f) To the best of your knowledge is patient following recommended treatment program? **Yes** _____ **No** _____ (If "No", please comment under "Remarks")

(g) If surgery is scheduled or has been performed, please provide details: _____

(h) Please forward results of current X-rays, tests or medical findings that may assist us in adjudicating this claim. **Please include any consultation reports.**

(i) Has there or will there be a referral to a specialist? **Yes** _____ **No** _____ If YES, please provide date of appointment _____

5. (a) To the best of your knowledge when did symptoms first appear or when did accident happen? Day _____ Month _____ Year _____

(b) Has the patient had the same or similar condition in the past? **Yes** _____ **No** _____ If "Yes", please state when and describe: __

_____

(c) Is the condition due to any injury or sickness arising out of the patient's employment? **Yes** _____ **No** _____ **Unknown** _____

(d) What aspect of the patient's daily living activities are impaired due to this disability? _____

(e) Are you aware of what your patient's normal job duties entail? **Yes** _____ **No** _____

6. (a) To the best of your knowledge, is the patient "Totally Disabled" (completely unable to engage in his or her normal occupation)? **Yes** _____

From: Day _____ Month _____ Year _____ To: Day _____ Month _____ Year _____

Please advise of approximate date when patient should be able to return to work: Day _____ Month _____ Year _____

If indefinite, please estimate the number of additional weeks before recovery _____ weeks.

No _____

If "No", please advise of date the patient was no longer "Totally Disabled": Day _____ Month _____ Year _____

REMARKS: (Please provide further details or additional information you believe may be helpful)

Physician's Name
(Please Print) _____ Address _____

Tel # _____ Fax # _____ _____

Signature _____ M.D. Date _____

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR ANY FEE CHARGED FOR ITS COMPLETION

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