TEAMSTERS' NATIONAL BENEFIT PLAN
WEEKLY INDEMNITY CLAIM FORM

2024 REVISION

Please have this form completed in the following order:

1. **Complete in full 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 or Email benefits.pensions@teamstersbenefits.ca Phone 604-552-2650 Fax 604-552-2653 TF 1-888-478-8111**

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF BECOMING DISABLED

EMPLOYEE'S STATEMENT

Member Last Name | Member First Name | Member/Certificate ID Number

Member address | Member phone | Date of birth: (DD/MM/YR)

Name of employer | Your regular occupation

1. Date you became totally disabled (unable to work) Day Month Year	8. What treatment are you doing to assist in your recovery?
2. Date last worked Day Month Year	9. Has a referral been made: Yes ☐ No ☐ If yes, provide details (Physician's name and date)
3. Date of first treatment (since totally disabled) Day Month Year	10. Date you expect to return to work: Day Month Year
4. a. Is disability due to Occupational injury or sickness? Yes ☐ No ☐ b. Has a claim been filed with WorksafeBC? Yes ☐ No ☐ c. Have you obtained assistance from the Workers' Advisers office? Yes ☐ No ☐	11. Accident information (**Complete only if claim is the result of injuries sustained in an accident)** a. Date of accident: Day _____ Month _____ Year _____ b. Time of accident: _____ AM ☐ PM ☐
5. Nature of disability:	12. Description of accident:
6. Physician's Name:	13. Are you receiving, or have you applied for Disability benefits from **any other source? If yes give details** (I.E. Employment Insurance, WorksafeBC, ICBC etc.) Yes ☐ No ☐
7. Are you engaged in any other occupation? If yes, please provide details under "Comments" 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 ☐ Laid off ☐ Vacation ☐ Other ☐

Is disability due to occupational injury or sickness? Yes ☐ No ☐

Has a claim been filed with WorksafeBC? Yes ☐ No ☐

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

Occupation: _____

Date employee last worked: _____

Date employee last paid: _____

Date employee returned to work: _____

Employer _____ **Authorized Signature** _____

Date _____ **Print Name** _____

Email _____ **Telephone** _____

ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT) **DISABILITY BENEFIT**

Please return completed form to your patient

1. Patient's Name Age: _____
Height : _____
Weight: _____

2. (a) Primary diagnosis of present condition:

(b) Secondary and/or Complications:

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

(b) Date of all subsequent visits since being absent from work (DD/MM/YR) _____

(c) Were you actively supervising the patients 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 treatment including medications dosage and frequency _____

(f) Has the patient had the same or similar condition in the past? Yes ☐ No ☐ If "Yes" please describe _____

_____

(g) To the best of your knowledge, is patient following recommended treatment program? Yes ☐ No ☐ (if "No" please comment under "Remarks")

(h) Has there or will there be a referral to a specialist? Yes ☐ No ☐ If "Yes", provide date of appointment _____

(i) Has surgery been scheduled or performed? Yes ☐ No ☐ If "Yes" provide surgery date and name of procedure: _____

_____

(j) Attach any current consultation reports, hospital reports, x-rays, tests, bloodwork etc. that may assist us in the adjudication of this claim.

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

(b) Is the condition due to an injury or sickness arising out of the patient's employment Yes ☐ No ☐ Unknown ☐

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

(d) How does present condition affect patient's ability to work? (ie restrictions & limitations) _____

5. (a) To the best of your knowledge, is the patient **"Totally Disabled" (completely unable to engage in their normal occupation)?** Yes ☐ No ☐
If "No" (please comment under remarks)

Indicate period patient has been unable to work. **From**: Day _____ Month _____ Year _____ **To** Day _____ Month _____ Year _____
(inclusive)

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.

(b) Is patient able to return to work on a graduated or modified basis? Yes ☐ No ☐ If "Yes" indicate date (DD/MM/YY) _____

REMARKS - Please provide further details or additional information you believe may be helpful.

Physician's Name _____

Telephone # _____ **Fax #** _____

Signature _____ **M.D.**

Date (DD/MM/YY) _____

Physician's stamp

THE PATIENT IS RESPONSIBLE FOR ANY CHARGES RELATED TO THE COMPLETION OF THIS FORM