THE LABOURERS' MULTI-LOCAL WELFARE TRUST FUND OF ONTARIO

ADMINISTRATOR: GLOBAL BENEFITS

MAJOR MEDICAL AND DISABILITY CLAIM FORM

INSTRUCTIONS TO EMPLOYEE

1. Complete the Employee's statement (below) on each form sent in.
2. Your plan is integrated with Employment Insurance (E.I.) Sickness Benefits. Therefore, you must apply for both Weekly Sick Pay through the Administration Office and E.I. Sickness Benefits as soon as you become disabled.
3. All correspondence, claim forms etc. should be mailed to:
   Global Benefits
   88 St. Regis Crescent South, Toronto, Ontario M3J 1Y8
   Phone: (416) 635-6000 Fax: (416) 635-6464
4. Pharmaceutical (drugs) receipts should be attached to this form.
5. A Separate claim form is required for each disability.
6. Please show your Social Insurance Number and date of birth.

DATE OF BIRTH

D	M	Y

Social Insurance Number: | | | | | | | | | |

EMPLOYEE'S STATEMENT

1. Name — Address (Give Number, Street, City & Prov.) — Home Phone No.

2. Single or Married ☐ ☐ — Male or Female ☐ ☐ — Occupation — Postal Code (at home)

3. IF DEPENDENT CLAIM, please complete.

Name of Dependent — Male or Female ☐ ☐ — Relationship — Date of Birth ____/____/____ (Day, Month, Year) — Single or Married ☐ ☐

Have you (or your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If "Yes", name of Employer and Insurance Co.

If "Yes", please indicate spouse's date of birth.

If child, indicate ☐ Student ☐ Handicapped

4. For **Weekly Disability Claim** please complete the following:

Date last worked ____/____/____ (Day, Month, Year) ☐ A.M. ☐ P.M.

If disability was the result of an accident injury, please give details below:

(a) When did it happen? Date ____/____/____ (Day, Month, Year) Time ________ ☐ A.M. ☐ P.M.

(b) Where did it happen? At Home ☐ At Work ☐ Elsewhere ☐

NOTE: Claims for work related disability must be filed with the Workplace Safety Insurance Board.

If accident was at work, provide name and address of employer: ____________________

(c) How did it happen? ____________________

____

Is this disability the result of an automobile accident? ☐ Yes ☐ No

If "Yes", you **must** file a claim for no fault insurance coverage with your insurance company.

I certify the above statements are true and I authorize all medical practitioners who may have attended or examined me or my dependent and all hospitals to furnish the Administrator: Global Benefits, all information with respect to this claim.

Date ____/____/____ (Day, Month, Year) Employee's Signature ____________________

As soon as you return to work, please inform Global Benefits

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ____/____/____ Signature of Member ____________________ Telephone Number (   ) ____________

Instructions
1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

ATTENDING PHYSICIAN'S STATEMENT

SD3 (LOSS OF TIME BENEFIT)
APPROVED BY CMA, AMLFC, CLHIA

Please return completed form to your patient

Part 1: Patient Authorization

Policy No.

Name

Date of birth *(day, month, year)*

I hereby authorize the release to my Insurer, my Policyholder and its Administrator Global Benefits of any information in respect of this claim.

Patient's Signature

Date *(day, month, year)*

Part 2: Attending Physician's Statement

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened *(day, month, year)*

   b) has patient had same or similar condition
   ☐ No ☐ Yes If yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment
   ☐ Yes ☐ No ☐ Unknown

4. Is condition due to injury or sickness arising out of an auto related accident
   ☐ Yes ☐ No ☐ Unknown

5. If patient is/was pregnant indicate date or expected day of confinement *(day, month, year)*

6. Date of hospital in-patient admission *(day, month, year)*

   Date of discharge *(day, month, year)*

7. Nature of treatment *(e.g. date and type of surgery)*

8. a) If patient was referred to you, give name of referring physician

   b) If you have referred patient to a specialist, give name(s) of physicians

9. a) Date of first visit during present period of absence from work *(day, month, year)*

   b) Date of latest attendance *(day, month, year)*

   c) Were you actively supervising this patient's care during the full period
   ☐ No, comment in remarks
   ☐ Yes, state frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify)

10. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition

    From *(day, month, year)*

    To *(day, month, year)* inclusive

    b) If still unable to work, give approximate date patient should be able to return *(day, month, year)*

    or, the estimated number of weeks before possible return

11. Please advise how present condition affects patient's ability to work *(for example restrictions, limitations, proposed surgery, etc.)*

12. Remarks – Please provide comments and further details which you feel would be helpful

Name of attending physician (please print)

Speciality

Telephone no.
( )

Address *(number, street, city, province, postal code)*

Signature

Date *(day, month, year)*

The patient is responsible for securing this form and for charges made for its completion.