Waterfront Employers
British Columbia

400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

WEEKLY INDEMNITY BENEFIT CLAIM FORM
ILWU – Employer Association Health & Benefit Plan

- **A 3 day waiting period** will apply for all claims, commencing the day of your **initial Doctor's visit**.
- You must submit this form to Employee Services within **30 days** of that initial Doctor's visit to avoid a late claim.
- Payment for Weekly Indemnity claims will not be made until a Physician's Statement is submitted to Employee Services for review, and you have submitted the original claim forms.
- Claims received by Employee Services after **12:00noon on Tuesday** will be processed the following week.
- No benefit amount will be payable during the period the Plan Member is outside of Canada for more than two weeks unless the Plan Member has Trustees approval.

Name: ______________________________ Employee #: ________________________

Union Local: _____________________ Telephone #: ______________________________

Date Disability Started: ________/________/__________
Day Month Year

NATURE of DISABILITY (please describe): ____

Is this disability the result of: an ILLNESS ☐ - or - an INCIDENT ☐ (eg.injury, accident, etc.)

Were you treated at a Hospital? YES ☐ NO ☐

Name of Hospital & Dates of treatment:____

<u>If this disability is the result of an **INCIDENT**</u>:

Please explain how the INCIDENT happened: ____

Where did the incident occur? Work ☐ Home ☐ Vehicle ☐ Other ☐

Did you file a Police Report? YES ☐ NO ☐

<u>If this disability occurred at **WORK**</u>: ***(copies of WorkSafeBC correspondence are required)***

WorkSafeBC Claim # ______________

1. Are you currently receiving, or have you ever received, WAGE LOSS or PENSION benefits from WorkSafeBC for the same or a related condition? **(if "YES", attach WorkSafeBC correspondence)** YES ☐ NO ☐

2. Are you currently appealing, or do you intend to appeal, a decision by WorkSafeBC regarding the same or a related condition? YES ☐ NO ☐

Waterfront Employers
British Columbia

400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

If this disability is the result of a **MOTOR VEHICLE ACCIDENT (MVA)**:

ICBC Claim #:_________________________ ICBC Adjuster (Name):_______________________

Your Lawyer (name):_________________________ Lawyer Phone #:__________________________

1. Were you the driver of the vehicle involved in the accident? YES ☐ NO ☐
2. Was this a Single Vehicle Accident? YES ☐ NO ☐
3. Did the accident occur in British Columbia? YES ☐ NO ☐
4. Did the accident involve persons residing outside of BC? YES ☐ NO ☐

If your disability occurred at work or was the result of an MVA or involved another 3rd Party, your claim may be managed as a LOAN repayable to the Plan when your WorkSafeBC, ICBC or legal claim is settled. **Therefore, you will need to sign a Reimbursement Agreement before your claim will be accepted.**

Weekly Indemnity Payments: **Direct Deposit ONLY**

Please complete Direct Deposit form and have your bank verify the information or attach a void cheque.

EMPLOYEE CERTIFICATION & CONSENT

- I hereby certify that the information provided on this form is complete and true to the best of my knowledge and belief.
- In the event that an overpayment is made or should I fail to make full reimbursement to the Plan, I irrevocably authorize the Waterfront Employers of BC (WEBC) to deduct up to $500 from my weekly pay until full re-payment is made, and apply applicable interest to the outstanding balance. Any outstanding balance owed may also be deducted from my vacation pay.
- Where applicable, I hereby authorize each and every physician, health care professional, hospital, health care institution or provider to provide to or exchange with WEBC all information and documents requested concerning my medical or behavioral health condition relative to this claim for the purpose of facilitating the delivery of best practice medical care and the assessment of my ability to work. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner.

Employee Signature: ________________________________ Date: ___________________

FOR ADMINISTRATIVE PURPOSES ONLY

Coverage: YES / NO Claim #: __________ Last Day Worked: ______________________
(DD/MM/YY)