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:_____

If this disability is the result of an **INCIDENT**:

Please explain how the INCIDENT happened: _____

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

Did you file a Police Report? YES ☐ NO ☐

If this disability occurred at **WORK**: ***(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 ☐

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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)

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WEEKLY INDEMNITY PHYSICIAN STATEMENT
ILWU – Employer Association Health & Benefit Plan

PATIENT NAME: _____ EMPLOYEE #: _____

ATTENDING PHYSICIAN STATEMENT:

Primary Diagnosis for current disability (please describe):

Please describe the signs and symptoms of this condition preventing patient from working:

Is there a **Secondary condition** contributing to the present condition? If so, please describe.

Has the patient ever developed the same or a similar condition? If so, when?

Date of commencement of disability: _____

Date of first visit for present disability: _____

Dates of subsequent visits for present disability: _____

Is there currently evidence of alcohol or drug abuse? YES ☐ NO ☐

Is the current disability the result of alcohol or drug abuse? YES ☐ NO ☐

Was the patient admitted to hospital for treatment? YES ☐ NO ☐

If YES, please provide dates of hospitalization _____

Is surgery required as treatment for this condition? YES ☐ NO ☐

If YES, please provide date of surgery _____

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TREATMENT PLAN

Please specify any Specialist Referrals made:

Required Treatments (please specify those that apply):

- ☐ Medication
- ☐ Physiotherapy
- ☐ Chiropractor
- ☐ *Psychologist
- ☐ Massage Therapy
- ☐ *Psychiatrist

*Please provide DSM number: _____

Please provide frequency of treatments above:

If medications are required, please provide drug name and dosage:

Are further tests required to complete a diagnosis or treatment plan? If so, what tests are pending? When?

Is patient currently medically fit for work? YES ☐ NO ☐

If NO, state anticipated time of recovery _____
(DD/MM/YYYY)

If a specific recovery date in unknown at present, please provide reason:_____

Doctor's Signature: _____ Date: _____

Specialty: _____ Telephone # _____

Official Stamp Required for Doctor's Name & Address

Doctor's Name:
Street:
City:
Postal Code:

PATIENT AUTHORIZATION

I, the undersigned, hereby irrevocably authorize any physician or other health professional, any hospital, or other medical or paramedical organization, or any other person or legal entity who has or who may have, in the future, information on me or my state of health or who has access to such information, to disclose same to the administrator of the ILWU – Employer Health & Benefit Plan.

Signature of Patient: _____ Date: _____

LONGSHORE

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Confidential Bank Information for Direct Deposit

WEEKLY INDEMNITY

To ensure credit to the correct account, please attach a VOID cheque and return to the above address. If you don't have a cheque, please have your financial institution complete and verify the BANK ACCOUNT section before returning the form **

Bank Account Name	Surname		Given Name	
Bank Account	Transit #	Bank# 0	Account #	
Bank Address				
			Bank Phone:	

Members Signature

Employee Number

Date

****THIS FORMS MUST HAVE AN OFFICIAL RUBBER STAMP BY THE FINIANCIAL INSTITUTION OR AN ATTACHED VOID CHEQUE.**

THIS FORM WILL NOT BE ACCEPTED IF THIS INFORMATION IS NOT PROVIDED.**