Weekly Indemnity Claim Form

Group Claims Department

Insured Member – complete this section. Please print clearly.

1.	Name of Union **Saskatchewan Piping Industry**			Local
2.	Group Insurance Policy Number	Occupation		Social Insurance Number
3.	Name			Date of Birth ((dd/mm/yyyy)
4.	Street Address			
	City/Town	Province		Postal Code
5.	On what date were you first disabled and unable to work? (dd/mm/yyyy) ❑ AM ❑ PM			On what date do you expect to return to work? (dd/mm/yyyy)
6.	Is disability due to an accident? ❑ Yes ❑ No	If "YES", please answer the following questions.	When did it happen? (dd/mm/yyyy)	Time: ❑ AM ❑ PM
	Where did it happen: ❑ at home ❑ at work ❑ elsewhere (name place)		How did it happen?	
7.	On what date were you first treated by a physician for this disability?		(dd/mm/yyyy)	
8.	List names and addresses of physicians who have treated you in conntection with this disability.			
9.	Have you been hospitalized in connection with this disability? ❑ Yes ❑ No	If "YES", please indicate name of Hospital:	Dates Hospitalized: From (dd/mm/yyyy)	To (dd/mm/yyyy)
10.	Are disability benefits payable from any other source as the result of this sickness or injury? ❑ Yes ❑ No	If "Yes", give name of source:		
11.	The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to and use by Global Benefit Plan Consultants Inc. of any medical or other information that may be required to establish the validity of this claim and further empower said Company to disclose any personal or claim information needed for medical case review or study. A photocopy of this release shall be as valid as the original.			

Date | Insured Member's Signature

Employer or Business Agent – complete this section. Please print clearly.

1.	On what date did this Insured Member last work (dd/mm/yyyy)					Number of Hours	
2.	What was the reason for leaving work? (check appropriate box)	❑ Disability	❑ Dismissed	❑ Temporary Layoff	❑ Strike	❑ Quit	❑ Retired
3.	If Insured Member became disabled while on Layoff, what was the date he/she was recalled and was unable to report to work? (dd/mm/yyyy)						
4.	Is this disability due to an occupational sickness or injury? ❑ Yes ❑ No			If "YES", has a claim been made for Workers Compensation Benefits ❑ Yes ❑ No			
5.	Do you expect insured Member to return to work? ❑ Yes ❑ No			If "YES", give expected date of return (dd/mm/yyyy)			

Date | Signature | Title

Member – send completed forms to:

Global Benefit Plan Consultants Inc.
88 St. Regis Crescent South
Toronto, Ontario M3H 1V2
Phone 416-635-6000 or Fax 416-635-6464

GLOBAL BENEFITS

Attending Physician's Statement – Please return completed form to your patient

1.	Patient's Name			Age	
2.	Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown				
3.	Diagnosis of present condition (a) Primary (b) Secondary (if applicable) (c) If appropriate – Additional conditions which might affect the duration of disability				
4.	To the best of my knowledge (a) Symptoms first appeared or accident happened		Month	Day	Year
	(b) Patient has had same or similar condition	❑ Yes ❑ No	If "YES", state when and describe		
5.	Date of hospital in-patient admission		Month	Day	Year
	Date of discharge		Month	Day	Year
6.	If surgery performed, describe. Date:	7.	If referred to you, give name of referring physician		
8.	(a) Date of first visit for present period of disability		Month	Day	Year
	(b) Date of latest attendance		Month	Day	Year
	(c) Were you actively supervising this patient's care during the full period?	❑ No If "NO", please comment in Question 12. ❑ Yes If "YES", state frequency of visits	❑ weekly	❑ monthly	❑ other (specify)
9.	If condition is due to pregnancy, what is (or was) the expected date of confinement?		Month	Day	Year
10.	(a) To the best of my knowledge, this patient has been Totally Disabled (unable to work)	From	Month	Day	Year
		To *inclusive*	Month	Day	Year
	(b) If still disabled, give approximate date when patient should be able to return to work.		Month	Day	Year
	(c) or, if indefinite, the estimated number of additional weeks before such return				weeks
11.	How long was or will patient by Partially Disabled? (able to work part-time at own occupation)	From	Month	Day	Year
		To *inclusive*	Month	Day	Year
12.	How does present condition affect patient's ability to work?				
	Additional remarks				

Physician's Name (please print)	Address	
Telephone Number *(include area code)*	Physician's Signature	Date

I hereby authorize the release to my insurer and my policyholder of any information requested in respect of this claim.

Telephone Number *(include area code)*	Patient 's Signature	Date

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