

CANADIAN ELEVATOR INDUSTRY WELFARE PLAN

Weekly Disability Income - Statement of Claim

SECTION 1 - TO BE COMPLETED BY THE MEMBER (please print)

MEMBER'S NAME (Last)		(First)	
ADDRESS (Number, Street, City, Province)			POSTAL CODE
PHONE NUMBER ()	DATE OF BIRTH Day Month Year	SOCIAL INSURANCE NUMBER	GROUP PLAN NUMBER

1. On what date were you first disabled and unable to work? Day | Month | Year Time a.m. / p.m.

2. On what date do you expect to return to work? Day | Month | Year

3. Is disability due to an accident? NO YES
If "YES" please answer the following questions:

a) When did it happen? Day | Month | Year Time a.m. / p.m.

b) Where did it happen? at home at work
 elsewhere (name place) _____

c) How did it happen? _____

4. On what date were you first treated by a physician for this disability? Day | Month | Year

5. List names and addresses of physicians who have treated you in connection with this disability.

6. Have you been hospitalized in connection with this disability? NO YES If "YES" please indicate:
Name of hospital: _____

Dates hospitalized: FROM Day | Month | Year TO Day | Month | Year

7. Are disability benefits payable from any other source as the result of this sickness or injury? NO YES
If "YES" give name of source: _____

8. I hereby certify that the above statements are true, accurate, and complete to the best of my knowledge and belief. I understand that Manion, Wilkins & Associates Ltd will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and administration of my benefits. I hereby authorize Manion, Wilkins & Associates Ltd to evaluate or investigate my claim and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my employer, any licensed physicians or other health professionals, medical facility, any insurance company or government body and any other person or institutions to release relevant information to Manion, Wilkins & Associates Ltd solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Member's Signature Date

SECTION 2 - TO BE COMPLETED BY YOUR LOCAL BUSINESS REPRESENTATIVE (please print)

1. On what date did this member last work? Day | Month | Year Number of hours: _____

2. If Member became disabled while on Layoff, what was the date he/she was recalled and was unable to report to work? Day | Month | Year

3. Is this disability due to an occupational sickness or injury? NO YES
If "YES" has a claim been made for Workers' Compensation benefits? NO YES

4. Date returned to work: _____ □ □

Signed by: _____ Title: _____ Date: _____

ONCE COMPLETED, PLEASE FORWARD TO THE OFFICE OF THE ADMINISTRATOR AS INDICATED BELOW

Trust Fund Office: Manion, Wilkins & Associates Ltd., 500-21 Four Seasons Place, Etobicoke, Ontario M9B0A5 Telephone: (416) 234-5044
(800) 263-5621

