NDT Benefits
Career — Health — Security

# NDT Industry Health Benefit Plan

4250 CANADA WAY, BURNABY, BC V5G 4W6 Tel: (604) 299-7482 Fax: (604) 299-8136
Toll Free: 1-800-663-1356 www.ndtbenefits.org

## Weekly Indemnity Benefits Claim

(Claim must be filed within 30 days of becoming disabled.)

**Notice to Employee:**
Employer to complete appropriate section.
Doctor to complete Attending Physician's Statement on reverse.
*Claimant must be seen and treated by a Medical Doctor during period of disability.*
✱ **Employee MUST sign on both sides of form where indicated.**
If applicable under the terms of your contract, you will be required to make application for Employment Insurance sick benefits.
***These benefits are taxable. Income Tax will be deducted from your benefit payments.*** *Direct Deposit is available – please contact the Plan Administrator for details.*
**Email: wiclaims@datownley.com**

| 1. Member Last Name | First Name | | |
|---|---|---|---|
| 2. Member Address | | | |
| 3. City | 4. Province | 5. Postal Code | 6. Telephone ( ) |
| 7. Social Insurance Number | 8. Date of Birth (yr/mo/day) | 9. Sex ☐ Male ☐ Female | 10. ☐ Married ☐ Single ☐ Other |

| 11. Date last worked | 12. When did you become totally disabled (unable to work) Date Time A.M./P.M. |
|---|---|
| 13. If hospitalized, give name of hospital | 14. Dates confined to hospital IN OUT |
| 15. If returned to work, give date | 16. If not, give date you expect to return to work |
| 17. Name of attending physician **(please print)** | 18. Doctor's address |

19. Nature of disability

| 20. Accident Information — Complete only if claim is a result of injuries sustained in an accident. | | | |
|---|---|---|---|
| Date of Accident | Time of Accident at A.M. P.M. | Was work being done for an employer at the time of the accident? ☐ Yes ☐ No | If not at work, where did accident happen? |
| 21. Describe how accident happened | | | |

22. Are you receiving Employment Insurance Benefits? ☐ Yes ☐ No If Yes, for what amount?_____ For what period? _____

23. Have you been self-employed or employed elsewhere during this period of disability? If "YES", explain.

24. Are you entitled to any Disability Income Benefits provided by a government agency? ☐ Yes ☐ No
25. Are you entitled to any Disability Income under any other plan of group insurance? ☐ Yes ☐ No
26. If "YES", give policy number, name and address of the organization providing such benefits:

I understand that D.A. Townley collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

✱ Member Signature_____ Date _____
***(Both must be signed before claim can be assessed)***

## TO BE COMPLETED BY EMPLOYER

| Name of employer | | | Group # **52565** |
|---|---|---|---|
| Address | | | Average weekly earnings $ / Hourly Earnings |
| Date last worked and number of hours worked | Has employee been laid off? (if so, when) | Has employee returned to work? (if so, when) | Has employment been terminated? (if so, when) |
| Is disability due to occupational sickness or injury? ☐ Yes ☐ No | | Has claim been filed with Workers' Compensation Board? ☐ Yes ☐ No | *(If yes, date filed)* |
| Occupation | | Describe job duties fully | |
| Remarks | | | |
| Signed (employer's representative) Date | | | |
| Contact Phone Number | | Contact Email | |

## PATIENT AUTHORIZATION

Name **(PLEASE PRINT)**

DATE OF BIRTH Year | Month | Day

I hereby authorize the release, to D.A. Townley, my insurer, and my policyholder, of any information required in connection with this claim. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

DATE OF BIRTH Year | Month | Day

* PATIENT/MEMBER SIGNATURE _____

***(This must be signed before claim is assessed.)***

## ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

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 — Year | Month | Day
   (a) indicate when symptoms first appeared or accident happened
   (b) has patient had same or similar condition ☐ Yes ☐ No 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. If patient is/was pregnant, indicate due date or date of confinement. Year | Month | Day

5. Date of hospital admission Year | Month | Day — Date of discharge Year | Month | Day

6. Nature of treatment (eg. date and type of surgery, treatment including medication, dosage and frequency)

7. (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 and provide a copy of consultation reports.

8. (a) Date of first and all subsequent visits during present period of absence from work (year, month, day)

   (b) Were you actively supervising this patient's care during the full period?
   ☐ No If "No", please comment in remarks
   ☐ Yes If "Yes", state frequency ☐ Weekly ☐ Monthly ☐ Other (specify)

9. (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 Year | Month | Day TO: (inclusive) Year | Month | Day

   (b) If still unable to work, give approximate date when patient should be able to return **or** the estimated number of weeks before possible return Year | Month | Day

10. (a) How does present condition affect patient's ability to work? (eg. restrictions, limitations, proposed surgery etc.)

    (b) Is patient fit for trial return to work on part-time or modified basis?
    ☐ Yes ☐ No If "Yes", indicate date Year | Month | Day

    (c) Is patient a suitable candidate for a vocational rehabilitation program? ☐ Yes ☐ No

11. Remarks - Please provide comments and further details which you feel would be helpful.

| Name of attending physician (Print) | Specialty (Print) | Physician's Stamp Here |
|---|---|---|
| Telephone Number ( ) | Signature | Date (yr/mo/day) |

***Any charge for completing this form is patient's responsibility.***