NDT Industry Health Benefit Plan

PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATOR

NDT Industry Health Benefit Plan
45 McIntosh Drive Markham, ON L3R 8C7

WEEKLY INDEMNITY BENEFITS CLAIM

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

NDT Benefits
Career — Health — Security

Notice to Member

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.

✱ Member **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: disability@ndtbenefits.org

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	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 the Plan Administrator 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 the Plan Administrator 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 the Plan Administrator, 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 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
   (a) indicate when symptoms first appeared or accident happened Year | Month | Day
   (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.