



TEAMSTERS' NATIONAL BENEFIT PLAN WEEKLY INDEMNITY CLAIM FORM

2014 REVISION

Please have this form completed in the following order:

INSTRUCTIONS TO EMPLOYEE

1. Complete and sign the "Employee's Statement". Sign the bottom of the reverse side of the form.
2. Have Employer complete "Employer's Statement".
3. Have your doctor complete the "Attending Physician's Statement" on the reverse of the form.
4. Send form to:

Teamsters' National Benefit Plan, 1610 Kebet Way, Port Coquitlam, B.C. V3C 5W9 Phone: 604-552-2650 Fax: 604-552-2653

EMPLOYEE'S STATEMENT: (Complete in FULL)

Full name of employee: _____

Address: _____

No.	Street	City or Town	Prov.	Postal Code
Date of birth:	Height:	Weight:	Social Insurance Number	Telephone Number

Name of employer:	Your normal occupation:
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1. Date accident or sickness began	Day Month Year	7. If disability is the result of an injury:
2. Date last worked	Day Month Year	
3. Date of first treatment	Day Month Year	a. Where did accident happen?
4. a. Was disability incurred in the course of your employment?	Yes No	b. Describe the accident: (attach additional information if necessary)
b. Have you filed or do you intend to file a WorkSafe BC (formerly WCB) claim?	Yes No	
5. Nature of sickness or injury:		c. At what time of day did accident occur?
6. Physician's name and address:		8. Date you returned to work or expect to return to work:
10. Are you engaged in any other occupation?	Yes No	9. Are you receiving or have you applied for disability benefits from any other source? If yes give details under "Comments":
Comments:		Yes No

I certify that the above statements are correct and hereby authorize my physician and hospital to release any additional information required in connection with this claim to the Teamsters' National Benefit Plan. I consent to the Teamsters' National Benefit Plan using this personal information to adjudicate my claim and disclosing this personal information when required by or permitted by law. I consent to the personal information provided above being retained, used and disclosed only in accordance with the Teamsters' National Benefit Plan privacy policy. I fully understand that I am not entitled to receive weekly indemnity benefits under this Plan during any period for which I receive WorkSafe BC (formerly WCB) Benefits or during any period for which I receive vacation pay.

I also hereby authorize the Teamsters' National Benefit Plan ("the Plan") to release medical information/correspondence pertaining to my disability benefits to physicians as required to obtain further medical information. I release and hold harmless the Teamsters' National Benefit Plan and its employees from any and all liability of any kind for circumstances that may arise as the result of the release of this information.

Date _____ Employee's Signature _____

IMPORTANT THE INCOME TAX ACT PROVIDES THAT YOUR WEEKLY INDEMNITY BENEFITS ARE SUBJECT TO INCOME TAX. IF YOU WISH TO HAVE INCOME TAX DEDUCTED FROM YOUR BENEFITS EACH WEEK AT A RATE OF 10% OF BENEFIT, PLEASE SIGN BELOW:	
DATE _____	EMPLOYEE'S SIGNATURE _____

EMPLOYER'S STATEMENT

Employee's regular hourly wage rate: _____

If dependent contractor, 12 month gross _____

Number of hours worked in a regular work week immediately prior to commencement of disability. _____

On date of disability, was employee: Actively employed Terminated

Was disability incurred in course of employment? _____

Employee type: Regular Employee - Union
 Regular Employee - Non-Union
 Dependent Contractor

Normal Occupation _____

Date employee last worked _____

Laid Off Other

Date employee returned to work _____

Date _____ Employer _____

Telephone _____ Authorized Signature _____

1. Patient's Name and Address _____
Age _____
Height _____
Weight _____

2. Diagnosis of Present Disabling Condition _____

3. Additional Conditions Which Affect the Duration of Disability _____

4. TREATMENT

(a) Date of patient's first visit for this disability Day _____ Month _____ Year _____

(b) Date of patient's most recent visit for this disability Day _____ Month _____ Year _____

(c) Were you actively supervising the patient's care during the full period? **Yes** _____ **No** _____ (If "No", please comment under "Remarks")

(d) Please state frequency of visits: Weekly _____ Monthly _____ Other (please specify) _____

(e) Please specify **nature of recommended treatment**: _____

(f) To the best of your knowledge is patient following recommended treatment program? **Yes** _____ **No** _____ (If "No", please comment under "Remarks")

(g) If surgery is scheduled or has been performed, please provide details: _____

(h) Please forward results of current X-rays, tests or medical findings that may assist us in adjudicating this claim. **Please include any consultation reports.**

(i) Has there or will there be a referral to a specialist? **Yes** _____ **No** _____ If YES, please provide date of appointment _____

5. (a) To the best of your knowledge when did symptoms first appear or when did accident happen? Day _____ Month _____ Year _____

(b) Has the patient had the same or similar condition in the past? **Yes** _____ **No** _____ If "Yes", please state when and describe: _____

(c) Is the condition due to any injury or sickness arising out of the patient's employment? **Yes** _____ **No** _____ **Unknown** _____

(d) What aspect of the patient's daily living activities are impaired due to this disability? _____

(e) Are you aware of what your patient's normal job duties entail? **Yes** _____ **No** _____

6. (a) To the best of your knowledge, is the patient "Totally Disabled" (completely unable to engage in his or her normal occupation)? **Yes** _____

From: Day _____ Month _____ Year _____ To: Day _____ Month _____ Year _____

Please advise of approximate date when patient should be able to return to work: Day _____ Month _____ Year _____

If indefinite, please estimate the number of additional weeks before recovery _____ weeks.

No _____

If "No", please advise of date the patient was no longer "Totally Disabled": Day _____ Month _____ Year _____

REMARKS: (Please provide further details or additional information you believe may be helpful)

Physician's Name (Please Print) _____ Address _____

Tel # _____ Fax # _____

Signature _____ M.D. Date _____

