SHEET METAL WORKERS LOCAL UNION 30 WELFARE PLAN

MATERNITY LEAVE BENEFIT STATEMENT OF CLAIM

Personal Health Information

MEMBER – complete this section. Please print.

1. **Member's Name:** _____ **Date of Birth:** _____/_____/_____
   Day Month Year

2. **Address:** _____
   Street City

   Province _____ **Postal Code** _____ **Phone No.** _____

   Email: _____

3. **Social Insurance Number:** _____

4. **Last Day Worked:** _____

   On what date were you unable to work due to your condition?

   _____/_____/_____ **at** _____ **a.m.** ☐ **p.m.** ☐
   Day Month Year

5. **Has your employer provided a separation certificate showing separation from employment?** ☐ **No** ☐ **Yes**

   i. **If Yes, please provide the separation certificate with your application.**
   ii. **If No, please contact your employer for this information.**

Member – submit completed Statement of Claim marked "PRIVATE" to:
Sheet Metal Workers Local Union 30 Welfare Plan, Disability Claims Team
45 McIntosh Drive, Markham, Ontario L3R 8C7
Phone: 905-946-9700 or toll free: 1-800-263-3564
Fax: 905- 946-2535
Or
send by encrypted email to ebps@mcateer.ca

8. **Have you filed a claim for, or are you currently receiving a pension or disability benefit from any of the following sources? (Please indicate "Yes" if you have filed a claim for this or any other disability from which you have not recovered, and provide the requested details of any pension or disability benefits you are receiving, whether they commenced before or after your current disability date)**

	I have filed a claim with:	I am receiving benefits from:
Canada/Quebec Pension Plan	□ Yes □ No	□ Yes □ No
Other Pension Plan	□ Yes □ No	□ Yes □ No
Other Group Policy	□ Yes □ No	□ Yes □ No
Workplace Safety and Insurance	□ Yes □ No	□ Yes □ No
Board or Workers' Compensation	□ Yes □ No	□ Yes □ No
Employment Insurance	□ Yes □ No	□ Yes □ No
Automobile Insurance	□ Yes □ No	□ Yes □ No
Other	□ Yes □ No	□ Yes □ No

a) If you are receiving pension or benefits from any of the above sources please complete the following:
b) If you are receiving or have applied for Employment Insurance, please indicate the date your claim commenced:
_____.
(day/month/year)

Source	Benefit Amount	How payable (lump sum, weekly, monthly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. **Have you done any type of work at all (for payment) since your date of disability? □ No □ Yes**

The above answers are true and complete according to the best of my knowledge and belief. I authorize the Plan Administrator to collect and exchange personal health information about me to process this claim and administer my group plan. I understand any personal health information obtained by the Plan Administrator will be kept confidential and, where necessary, the Plan Administrator will be exchanging my personal health information. I authorize the following persons to exchange with the Plan Administrator or each other, any of my personal health information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, my union, the Board of Trustees of the Sheet Metal Workers Local Union 30 Welfare Plan, government agency, auditing or independent investigative organization or financial institution. I have been given a copy of the Plan's privacy policy upon my request and consent to the use of my personal information for the management of my claim.

I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Member's signature _____ **Date** _____

Attending Physician's Statement

Instructions: 1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.

Part 1: Patient Authorization

Name	Date of Birth (Day/Month/Year)

I hereby authorize the release to the Sheet Metal Workers Local Union 30 Welfare Plan of any medical information in my file , for the purpose of administering the Maternity Leave Benefit program and assessing my claim.

Patient's Signature _____ Date: _____

Personal Health Information

Part 2: Attending Physician's Statement:

1. Expected Due Date:		
2. To the best of your knowledge, indicate period patient has already been unable to work at own occupation as a result of present condition from: _____ (day/month/year) to: _____ (day/month/year)		
Name of attending physician (please print)	Specialty	Telephone No. _____-_____-_____
Address (number, street, city, province, postal code)		
Signature	Date (day/month/year)	

PRIVACY STATEMENT: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal Information will be protected pursuant to the relevant privacy legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, insurers, re-insurers, regulators) in order to manage the Plan and your entitlement to the benefits of the Plan. Questions related to the Privacy Policy of the Plan should be directed to the Disability Benefits Administrator.