CONSTRUCTION AND SPECIALIZED WORKERS' MEDICAL AND BENEFIT PLAN OF BC

#100 – 19092 26th Avenue, Surrey BC V3Z 3V7
Phone - 604-538-6640 Toll Free – 1-800-964-3666 Fax – 604-538-6680

CLAIM FOR WAGE INDEMNITY BENEFITS

INSTRUCTIONS TO MEMBER (Please Print)

1. TO QUALIFY YOU MUST BE UNDER THE CARE OF A MEDICAL PRACTITIONER OR AND HAVE BEEN TREATED IN PERSON, DURING THE PERIOD YOU ARE CLAIMING WAGE INDEMNITY BENEFITS. IF YOU ARE ELIGIBLE, YOU MAY APPLY FOR WAGE INDEMNTIY BENEFITS FROM THE FIRST DAY YOU SAW YOUR DOCTOR.

   YOUR MEDICAL PRACTITIONER MUST VERIFY IN WRITING THAT YOU ARE UNABLE TO WORK AS A RESULT OF A NON-OCCUPATIONAL ACCIDENT OR SICKNESS.

2. COMPLETE THE MEMBER'S STATEMENT BELOW.

3. IT IS YOUR RESPONSIBILITY TO RETURN THE **ORIGINAL COMPLETED** FORM TO THE ADMINISTRATION OFFICE AT THE ABOVE ADDRESS.

MEMBER'S STATEMENT

NAME: _____

MBR #: _____

ADDRESS: _____

CITY/PROVINCE: _____

POSTAL CODE: _____

PHONE NUMBER: _____

Age: _____ Occupation: _____

1. Date you first became totally disabled _____
2. Date you first spoke to Physician/Public Health _____
3. Describe your illness or injury _____
4. Is your disability the RESULT of an accident? Yes _____ No _____

   If "Yes", please complete the following:

   a. When did the accident happen? _____
   b. Where did the accident happen? Home _____ Work _____ Elsewhere _____
   c. How did the accident happen? _____

      _____
5. Is any claim being made to Workers' Compensation for this disability? Yes _____ No _____

   Claim #_____
6. Have you applied for Employment Income (EI) benefits? Yes _____ No _____

   If "Yes" please indicate: Regular _____ Sickness _____
7. Name of your last employer(s): _____
8. Your last day worked: _____

A. I hereby authorize all medical practitioners who may have attended or examined me, and all hospitals, to furnish the Construction and Specialized Workers' Medical and Benefit Plan BC all information with respect to this claim.

B. I hereby certify the facts stated above are a true report and on the basis thereof request benefits to which I may be entitled from the Construction and Specialized Workers' Medical and Benefit Plan of BC. I agree that any benefits or payments made by the Plan shall be on the basis of these representations and without prejudice to the Plan's rights.

Member's Signature **Date Signed**

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CONSENT TO DISCLOSE CLAIM INFORMATION SERVICE CANADA - EMPLOYMENT INSURANCE

In order to process your Wage Indemnity claim with the Plan, we will require information on any existing or previous claims with Service Canada for Employment Insurance.

Information regarding your qualification and entitlement for regular and/or sickness benefits must be provided to the Plan to determine your eligibility and entitlement to the Wage Indemnity benefit.

This information contributes to efficiently adjudicating your submitted claim and is limited to the current claim under review.

In order for the Plan to communicate directly with Service Canada, it is necessary to have your consent to this disclosure. Please provide your authorization by completing the following and returning to the Plan office.

I, _____ S.I.N.#_____

Hereby give my consent to the Construction & Specialized Workers Medical and Benefit Plan to communicate with Service Canada and receive information with regards to existing or previous claims for Employment Insurance.

_____ _____
Member Signature Date

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CONSTRUCTION AND SPECIALIZED WORKERS' MEDICAL AND BENEFIT PLAN OF BC

Plan Member Confirmation of Illness Form

Member's Name: _____ MBR #: _____

Claim #: _____ Date: _____

Please only complete this form if your absence is due to the COVID-19 (novel coronavirus) symptoms or if you have a clinical diagnosis of the COVID-19 (novel coronavirus).

In recognition of the increasing pressure on our medical clinics and hospitals due to the global health emergency we will not, at the outset, require an Attending Physician's Statement as part of your Wage Indemnity Benefit claim submission, if your absence is due to COVID-19 (novel coronavirus) symptoms, a clinical diagnosis of the virus, or a quarantine order. This is a time limited exception as we move through the current situation.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms and any medical treatment you may have received for your condition. Please complete, sign and return this form to the Plan office.

Return the form promptly to:

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Surrey, BC V3Z 3V7
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Toll Free: 1-800-964-3666
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Email: inquiry@lmppbc.ca

TO BE COMPLETED BY MEMBER:

1. Please confirm: Date symptoms first appeared: _____ (dd/mm/yyyy)
2. First day absent from work: _____ (dd/mm/yyyy)
3. Please indicate the symptoms associated with your illness:

☐Fever	☐Decreased appetite
☐Cough	☐Runny nose
☐Fatigue	☐Nausea
☐Muscle aches	☐Vomiting
☐Sore throat	☐Headache
☐Shortness of breath	
☐Other_____	

4. Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)?_____

_____

5. What event(s) led to the potential exposure (e.g., travelled to the affected region, exposed to someone who is infected)?

_____

☐ I'm following Public Health recommendations to stay at home._____

_____

☐ Who directed you to self-quarantine (Public Health, Physician, Other – indicate who)?_____

_____

☐ Date(s) of medical consultation or date directed by Public Health to self-quarantine? _____
(dd/mm/yyyy)

☐ Name and phone number of medical authority/clinic/physician who instructed you to self-quarantine.

_____

6. Did you undergo a test for Coronavirus? Yes / No (circle one)

If yes, what were the results?: Positive or Negative (circle one)

If test results not received, when are they expected? _____ (dd/mm/yyyy)

If not tested, why not?_____

☐ When did the self-quarantine period start? _____ _____ _____
(dd/mm/yyyy)

☐ When do you expect the self-quarantine period to end? _____ ___ _____
(dd/mm/yyyy)

☐ When do you expect to return to work? ___ ___ _____
(dd/mm/yyyy)

☐ When are you next seeing your physician? ___ ___ _____
(dd/mm/yyyy)

7. Can you work from home? Yes No (circle one)

I certify that the statements on this form are true and complete and understand that further information may be required to validate my claim.

Name: _____Phone #:_____ Cell #:_____

Signature: _____ Date:_____

For more information on the novel coronavirus, go to the Public Health Agency of Canada's website at: https://www.canada.ca/en/public-health.html