UNITE HERE HEALTH & WELFARE PLAN

Administered by

Soben Management Ltd.

150 Consumers Road, Suite 302, Toronto, Ontario M2J 1P9

Tel: 416-498-8338 Toll Free: 1-888-887-6879 Fax: 416-498-4591

ACCIDENT & SICKNESS AND MATERNITY/PARENTAL CLAIM FORM

(Must be submitted within 90 days of last day worked)

Plan Member's Section: (To be filled out by the employee)

Last Name: _____ First Name: _____

Address: _____ Apt. No.: _____ S.I.N. No.:_____

City: _____ Province: _____ Postal Code: _____ Home Tel.: _____

Date of disability: | day | month | year |

Date of Birth: | day | month | year |

If an accident, where did it occur? Home ☐ Work ☐ Elsewhere: _____

Cause of disability: _____

I hereby certify that the above information is true. I authorize any medical practitioner, hospital, employer, UNITE HERE Local 75, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare and Pension Plans and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

Date: _____ Department: _____ Signature: _____

Please inform Soben Management Ltd. as soon as you return to work.

Employer's Section: (To be filled out by the employer)

Place of Employment: _____ Tel.: _____

Employment Address: _____

Reason for absence: _____

Was this an accident? yes ☐ no ☐ Is this a W.S.I.B. case? yes ☐ no ☐

Do you consider the disability to be the result of: a) Intentionally self-inflicted sickness or injury? yes ☐ no ☐

b) Pregnancy? yes ☐ no ☐

Did disability occur during employee's vacation? yes ☐ no ☐

If yes, specify vacation period: _____

Last day worked: | day | month | year |

Hourly rate of Pay: $ _____ / hr.

Date returned or expected to return to work: | day | month | year |

Regular days off: Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun. ☐

Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun. ☐

(if irregular indicate days off for sickness period)

Date: _____ Position: _____ Signature: _____

(This page must be filled out if absence is for more than 5 working days)

Physician's Section: (To be filled out by the attending physician)

1. Patient's Name: _____ Date of Birth:

day	month	year

2. Diagnosis: _____

_____

3. Is this a W.S.I.B. Case? yes ☐ no ☐

4. a) Is the patient pregnant? yes ☐ no ☐

   b) If yes, is the pregnancy the cause of this disability or injury? yes ☐ no ☐
   (if yes, please indicate below in item 10)

   Expected date of delivery:

day	month	year

5. Name of Hospital: _____

   Date Hospitalized:

day	month	year

   Date Discharged:

day	month	year

6. Name of referring physician: _____

7. Date of all office visits and procedure(s) performed:

day	month	year

   Procedure: _____

day	month	year

   Procedure: _____

   Anticipated physiotherapy: yes ☐ no ☐

8. a) Date of first consultation in connection with present conditions:

day	month	year

   b) Date of first symptoms of this condition:

day	month	year

   c) Follow-up appointment date:

day	month	year

9. a) This patient was totally disabled from:

day	month	year

   to

day	month	year

   b) If still disabled, indicate approximate date of return to work:
   (must be specific - may be changed later)

day	month	year

   c) If disability is not total, indicate on which date partial disability began:
   (Please try to assess whether this illness or injury is severe enough to cause total or partial disability from this employee's present job.)

day	month	year

10. Comments: _____

_____

Date:_____ M.D. Name: _____ Signature: _____

Address: _____ Tel: _____