Weekly Indemnity Claim Form

Insured Member – Complete this section. Please print clearly. **Policy No. _____**

1.	Occupation			Member Certificate Number	
2.	Name		Date Of Birth (dd/mm/yyyy)		
3.	Street Address				
	City/Town	Province	Postal Code		
	Phone Number	Email Address			
4.	On what date were you first disabled and unable to work _____/_____/_____ Day Month Year ▫ AM ▫ PM		On what date do you expect to return to work _____/_____/_____ Day Month Year		
5.	Is disability due To an accident ▫ Yes ▫ No	If "Yes", please answer the following question.	When did it happen? _____/_____/_____ Day Month Year	Time :	▫ AM ▫ PM
	Where did it happen: ▫ at home ▫ at work	▫ elsewhere (name place)	How did it happen?		
6.	On what date were you first treated by a physician for this disability?		(dd/mm/yyyy)		
7.	List name and address of physicians who have treated you in connection with this disability.				
8.	Have you been hospitalized In connection with this disability ▫ Yes ▫ No	If "Yes", please indicate name of hospital:	Dates Hospitalized: From: (dd/mm/yyyy)	To: (dd/mm/yyyy)	
9.	Are disability benefits payable from Any other source as the result of This sickness or injury? ▫ Yes ▫ No	If "Yes", give name of source:			
10.	By signing below, you confirm that, all statements you have made about your claim are true and complete. You authorize Global Benefits to collect and disclose your personal information that may be required to establish the validity of this claim including but not limited to healthcare and rehabilitation providers, insurance and reinsurance companies, administrators of government benefits and of other benefit programs, etc. A photocopy or electronic copy of this release shall be as valid as the original.				

Date	**Insured Member's Signature**
_____/_____/_____ Day Month Year	

Authorized Union Official – complete this section. Please print clearly.

1.	On what date did this insured Member last work (dd/mm/yyyy)					Number of Hours	
2.	What was the reason for leaving work? (check appropriate box)	Disability	Dismissed	Temporary Layoff	Strike	Quit	Retired
3.	If insured member became disabled while on layoff, what was the date he/she was recalled and was unable to report to work?	_____ Day	_____ Month	_____ Year			
4.	Is this disability due to an Occupational sickness or injury? Yes No	If "Yes", has a claim been made for Workers Compensation Benefits Yes No					
5.	Do you expect insured member To return to work? Yes No	If "Yes", give expected date of return (dd/mm/yyyy)					

Date	**Signature**	**Title**

Please scan & return completed forms to **disability@globalben.com** or Mail them to:
Global Benefits c/o Disability Department
901-191 The West Mall, Toronto ON, M9C 5K8
If you have any questions or concerns, please call Global Benefits at 1-800-663-4500 ext. 802

Attending Physician's Statement – Numbers marked with '*' are mandatory to be completed

1.*	Patient's Name			Age	
2.*	Is condition due to injury or sickness arising out of patient's employment	▫ Yes	▫ No	▫ Unknown	
3.*	Diagnosis of present condition (a) Primary (b) Secondary (If applicable)				
4.*	To the best of my knowledge (a) Symptoms first appeared or accident happened		Month	Day	Year
	(b) Patient has had same or similar condition	▫ Yes	▫ No	If "Yes", state when and describe	
5.	Date of hospital in-patient admission	Month	Day	Year	
	Date of discharge	Month	Day	Year	
6.	If surgery performed, describe, Date:	7.	If referred to you, give name of referring physician		
8.*	(a) Date of first visit for present period of disability		Month	Day	Year
	(b) Date of latest attendance		Month	Day	Year
	(c) Were you actively supervising this patient's care during the full period?	▫ No If "No", please comment in question 12. ▫ Yes If "Yes", state frequency of visits ▫ Weekly ▫ Monthly ▫ Other (specify)			
9.*	(a) To the best of my knowledge, this patient has been Totally Disabled) (Unable to work)	From _____ To Inclusive	Month _____ Month	Day _____ Day	Year _____ Year
	(b) If still disabled, give approximate date when patient should be able to return to work.		Month	Day	Year
	(c) Or, if indefinite, the estimated number of weeks before such return		_____		Weeks
10.	How long was or will patient by Partially Disabled? (able to work part-time at own occupation)	From _____ To Inclusive	Month _____ Month	Day _____ Day	Year _____ Year
11.*	How does present condition affect patient's ability to work?				

Please include any additional notes, consultations, etc. that may assist in reviewing this Member's application for Weekly Indemnity.

Physician's Name (please print)	Address

Telephone Number	Physician's Signature	Date
( ) _____ - _____		

I hereby authorize the release to my insurer and my policyholder of any information requested in respect of this claim.

Patient's Signature	Patient's Email	Date

The patient is responsible for securing this form and for charges made for its completion.