

LiUNA!care

LOCAL 183™

Member Health Management Services



LOCAL 183 MEMBERS' BENEFIT FUND
APPLICATION FOR SHORT TERM DISABILITY BENEFITS

SHORT TERM DISABILITY BENEFITS

Application Process & Eligibility Requirements

APPLICATION PROCESS

1. Confirm your Benefit Plan coverage at the onset of your disability;
2. Ensure you meet the eligibility requirements for this benefit;
3. Complete and sign the **Member Statement** section (page 1) of the Short Term Disability Application;
4. Ensure your current employer completes the **Employer Statement** (page 2);
5. Ensure the physician overseeing your medical care completes the **Attending Physician Statement** (page 3);
6. Obtain a Record of Employment (ROE) from your employer and apply for Employment Insurance Sick Benefits;
7. Keep all copies of the application forms along with any relevant medical documentation;
8. Return all portions of the Short Term Disability Application to LiUNA! Care 183 Member Health Management Services. If there are questions, please contact us so we can assist with your application;
9. All three (3) sections of the Application form are required to begin assessing your claim.

ELIGIBILITY REQUIREMENTS

- You must be a Member with Benefit Plan coverage on the date your disability started;
- You must be actively at work on the date you become disabled (if you are laid-off, on vacation, unemployed, or not working for any other reason at the onset of your disability, you are not eligible for this benefit);
- Employer contributions must have provided your Benefit Plan coverage on the day you become disabled (if your benefit coverage is being maintained through self-payment at the onset of your disability, you are not eligible for this benefit);
- You must be under age 70 at the onset of your disability;
- Your disability must be a result of a non-occupational illness or non-occupational injury;
 - If the injury or illness that prevents you from working is work-related, you must file a claim with the Workplace Safety & Insurance Board (WSIB). Health Management Services can assist you with your application.
- You must be diagnosed with a bona-fide medical condition which prevents you from working and performing the essential duties of your pre-disability job;
- You must be seen by, treated by, and under the continued care of a licensed physician (M.D.) in Canada;
- Benefits do not commence until you are seen by and treated by a physician;
- You must be absent from work for more than 7 days (waiting period), unless
 - Your disability is a result of a non-occupational accident, then the waiting period does not apply; or
 - You are hospitalized for at least 18 hours due to your illness, then benefits are payable from the first date of hospitalization.

SHORT TERM DISABILITY BENEFITS

Benefit Amount & Duration

BENEFIT AMOUNT AND DURATION

- Maximum benefit payments of \$500 per week less tax being withheld from each weekly benefit payment;
- Benefits are integrated with Employment Insurance (EI) Accident and Sickness benefits and you are required to apply for EI benefits;
 - If you qualify for EI benefits, Short Term Disability benefits will be frozen once EI benefits begin;
 - If you do not qualify for EI benefits, Short Term Disability benefits will be payable during this time provided you submit supporting documentation of your ineligibility for EI benefits.
- If you continue to be disabled after exhausting EI benefits, the Plan will resume Short Term Disability benefit payments provided you remain disabled and provide ongoing medical documentation to support your disability.
- A maximum benefit of \$100 is payable for the completion of the initial Attending Physician Statement portion of the Short Term Disability application, should your claim be approved;
- Short Term Disability Benefits commence on
 - The 17th week of disability (after the EI Accident and Sickness benefit period); or
 - The 8th day of disability if you do not qualify for EI Accident and Sickness benefits; or
 - The 1st day absent from work if the disability is a result of an accidental injury; or
 - The date you are hospitalized for over 18hrs.
- Short Term Disability benefits are payable to a maximum of 104 weeks from the start of your disability, inclusive of any weeks paid by EI.
- Short Term Disability Benefits end once
 - You return to active full-time work; or
 - You return to any work for pay or profit (excluding graduated return to work plans); or
 - You are deemed fit to return to your pre-disability job; or
 - You turn age 70; or
 - You reach the maximum benefit duration (104 weeks of disability).
- If you return to active work full-time work but sustain a subsequent disability, a new waiting period and benefit duration will start if you work:
 - Four (4) weeks before you again become disabled because the same or related cause;
 - One (1) week before you again become disabled because of a different or unrelated cause.
- If you are under age 65 and remain totally disabled beyond the maximum benefit duration, you may be eligible for Long Term Disability Benefits. Health Management Services will assist with your application for this benefit.

SHORT TERM DISABILITY BENEFITS

Ongoing Eligibility, Exclusions, & Limitations

ONGOING ELIGIBILITY

- If your claim is accepted, and to remain eligible for Short Term Disability benefits, you are required to
 - Remain under the continued care of a licensed physician (M.D.) in Canada; and
 - Be compliant with all aspects of your treatment plan including attending all recommended medical assessments, investigations, and treatment; and
 - Participate in modified work plans when available and deemed suitable; and
 - Communicate regularly with your Health Management Services case worker; and
 - Immediately notify Health Management Services of your return to work, your receipt of employment income, any change in your work status or availability to work, or any change in your medical status as it relates to your ability to work; and
 - Comply with requests deemed necessary for the ongoing assessment of your claim; and
 - Report for a medical examination as required to substantiate your benefit entitlement.

EXCLUSIONS & LIMITATIONS

- No Short Term Disability benefits will be paid for:
 - Any day you do any kind of work for pay or profit (excluding graduated return to work plans);
 - The period you are entitled to pregnancy or parental leave of absence by statute, contract, or employment agreement, except where benefits are provided during the post-natal recovery;
 - The period of illness or injury for which benefits are payable under the Employment Insurance (EI).
- No Short Term Disability benefits will be paid for any disability that results from or is contributed by:
 - War, whether declared or not;
 - Insurrection, rebellion, or participation in a riot or civil commotion;
 - Your commission of, or attempt to commit, an assault or criminal offense;
 - Purposely self-inflicted injury;
 - Any injury or illness caused by or contributed to by a motor vehicle accident. This applies to motor vehicle accidents which occur in the provinces of Ontario and Quebec.

The eligibility and benefit provisions set out above are general and for information only. The benefit booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

SHORT TERM DISABILITY BENEFITS

Benefit Extension & Other Important Information

EXTENSION OF INSURANCE COVERAGE DUE TO DISABILITY

- If you are totally disabled on the date your insurance terminates, entitlement to Extended Health Care, Dental Care, Emergency Out of Province and Life Insurance benefits will be the same as though such insurance had not terminated provided you submit proof to the Administrative Agent for as long as you remain continuously disabled, and are currently in receipt of Short Term Disability, Long Term Disability, or Canada Pension Plan (CPP) Disability Benefits, as follows:
 - Members on Short Term Disability will be required to remit a monthly payment of \$95.00 plus 8% R.S.T, a total of \$102.60 for continuous benefit coverage up to a maximum of twenty-four (24) months following the exhaustion of your Hour Bank Account provided you remain in receipt of Short Term Disability Benefits;
 - Members on Long Term Disability will be required to remit a monthly payment of \$95.00 inclusive of 8% R.S.T. for continuous benefit coverage provided you remain in receipt of benefits for disabilities on or after October 1, 2011;
 - Members on Canada Pension Plan (CPP) Disability Benefits will have their benefit coverage on a complimentary basis;
 - Eligibility for benefits will be conditional on you remaining a Member in Good Standing with L.I.U.N.A. Local 183;
 - You will be required to provide proof that you continue to be in receipt of the above benefits on an annual basis;
 - Coverage will terminate on the date of your death, return to employment, recovery or the attainment of age 65 for all benefits.

OTHER IMPORTANT INFORMATION

- Health Management Services will endeavour to notify you of any potential benefit(s) or service(s) you may be eligible to receive to assist you during your disability from work. Nonetheless, please refer to Benefits Booklet for information regarding benefits and services offered by the Plan.
- Payment of monthly Union dues is your responsibility to remain in Good Standing.
- If you anticipate being off work for a prolonged period, speak to the Labourer's Pension Fund for guidance on pension matters at 289-291-3663 or at 1-866-932-1100. Disability Pension Benefits will not affect your entitlement to Short Term Disability benefits.
- If you anticipate being off work for a prolonged period or have been diagnosed with a terminal illness, speak to your physician about applying for Canadian Pension Plan (CPP) Disability Benefits. Health Management Services can assist with your application for this benefit. Canadian Pension Plan benefits will not affect your entitlement to Short Term Disability Benefits.

If you have any questions your coverage or benefits, please do not hesitate to contact us

MEMBER STATEMENT

All three (3) sections of this application must be completed, signed, and submitted for the assessment of your claim for Short Term Disability Benefits.

1. Member Statement;
2. Employer Statement (or Record of Employment) completed by your Employer at the onset of your disability;
3. Attending Physician Statement completed by the Licensed Medical Doctor overseeing your care.

If any section of this application is not completed or portions are not answered fully, the assessment of your claim may be delayed.

Member Information

Last Name		First Name	Union ID Number
Address			Date of Birth
Town/City	Province	Postal Code	Telephone Number
Email Address			Cell Phone Number

Absence Information

Last Day Worked (mm/dd/yyyy)	First Day Absent due to Medical Condition	Return to Work Date
Expected Return to Work Date	Is your Condition due to an Accident? <input type="checkbox"/> No <input type="checkbox"/> Yes	Accident Date
Did the Accident Involve a Motor Vehicle? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the Accident or Medical Condition Work-Related? <input type="checkbox"/> No <input type="checkbox"/> Yes	WSIB Claim Number?

Describe the Nature of your Medical Condition and Accident, if applicable (time, location, activity being performed at time of injury)

Have you applied for, or are you receiving, any of the following Benefits?

Employment Insurance (EI) Benefits	<input type="checkbox"/> Applied	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Workplace Safety & Insurance Board (WSIB) Benefits	<input type="checkbox"/> Applied	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Motor Vehicle Accident Insurance Benefits	<input type="checkbox"/> Applied	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Canada Pension Plan (CPP) Benefits	<input type="checkbox"/> Applied	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Any Other Disability or Income Continuation Benefits	<input type="checkbox"/> Applied	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied

During your Absence, will you be working or receiving income from another employer or self-employment?

No Yes, Describe

Member Declaration & Authorization for Release of Information

I certify that the information presented is true, correct, and complete. I understand that for the duration of this claim, I must immediately notify LiUNA! Care 183 Member Health Management Services of my return to work in any capacity, my receipt of any employment income, and any change in my status as it relates to my ability to work or entitlement to Short Term Disability Benefits.

LiUNA! Care 183 is administered by Benefit Plan Administrators Limited (BPA) on behalf of the Local 183 Members' Benefit Fund. I hereby authorize BPA, administrators of the Local 183 Members' Benefit Fund, and its subsidiaries, to collect, use, and exchange any and all information and documentation requested by BPA regarding or relating to my medical or mental health condition for the purpose of assessing and managing my claim for short term disability benefits and access to other benefits and services provided by the Local 183 Members' Benefit Fund. This includes authorizing any physician, health care professional, hospital, public or private institution, my employer(s), and Union to provide to BPA any information required for the assessment or management of my claim for short term disability benefits. I also authorize BPA to share with my Long Term Disability Insurer any and all information and documentation collected should I be eligible for Long Term Disability benefits. All personal information will be treated in a highly confidential manner. It is understood that this authorization is valid from the date hereof through my return to work. This authorization may be withdrawn at any time upon receipt of written notification to BPA. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original. By signing below, I consent to the collection, use, and disclosure of my personal information as stated above.

Member Signature	Date
------------------	------

EMPLOYER STATEMENT

LiUNA! Care 183 - Member Health Management Services is responsible for reviewing medical absences to assess eligibility to benefits offered through the Local 183 Members' Benefit Fund and coordinating benefits and services to assist Members in their recoveries and return to work. The information below is required to assess the Member's ability to work and eligibility to Short Term Disability Benefits offered through the Benefit Plan.

Please complete the following information in full and return directly to the Member or send to LiUNA! Care 183 - Member Health Management Services. Please attach any additional information to help us understand the Member's absence, work duties, or physical demands of the job.

Member Information

Member's Last Name	Member's First Name	Union ID Number
--------------------	---------------------	-----------------

Employment Information

Job Title	Date of Hire (mm/dd/yyyy)	Gross Weekly Earnings
-----------	---------------------------	-----------------------

Member's Normal Work Schedule:

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							

Number of Hours Normally Worked per Week:

Provide a description of the Member's work duties or attach a job description or physical demands assessment

Last Day Worked	First Day Absent from Work	Actual or Expected Return to Work Date
-----------------	----------------------------	--

Reason for Work Absence

- Medical
 Lay-Off
 Dismissed
 Quit
 Leave
 Unknown
 Other

Has the Member Received Pay After the Last Day Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provide Date Pay Stopped
--	----------------------------------

Was the Member Recalled back to Work but Unable due to Medical Reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provide Recall Date
---	-----------------------------

Are Modified Duties Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are Modified Hours Available? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Declaration

I certify that the above information is true, correct, and complete.

Employer Contact Name	Title
Employer	Telephone
Employer Signature	Date

Please complete and return this form to

LiUNA! Care 183 - Member Health Management Services
 1263 Wilson Avenue, Suite 302, Toronto, ON, M3M 3G3
 Fax: 416-240-7047 | Email: memberhealthservices@liunacare183.ca

ATTENDING PHYSICIAN STATEMENT

LiUNA! Care 183 - Member Health Management Services is responsible for reviewing medical absences to assess eligibility to benefits offered through the Local 183 Members Benefit Fund and coordinating benefits and services to assist Members in their recoveries and return to work. The information below is required to assess your patient's ability to work and eligibility to Short Term Disability Benefits offered through the Benefit Plan. Please complete the following information in full and return directly to your patient or send to LiUNA! Care 183 - Member Health Management Services. Please attach any additional information that would help us understand the nature or extent of the patient's medical status or absence from work. Any fees associated with the completion of this form is the responsibility of the patient.

Patient Information

Patient's Last Name	Patient's First Name	Date of Birth
---------------------	----------------------	---------------

Medical Information

Date Symptoms First Appeared	Date of First Visit after Work Absence	Date Condition First Prevented Patient from Working
------------------------------	--	---

Is the he Condition a Result of an Accident? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the Accident or Condition Work-Related? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is Condition a Result of a Motor Vehicle Accident? <input type="checkbox"/> No <input type="checkbox"/> Yes
--	--	--

Primary Diagnosis

Secondary Diagnosis and Additional Conditions

Restrictions and Limitations - What specifically prevents your patient from performing his/her job duties?

Hospitalization <input type="checkbox"/> No <input type="checkbox"/> Yes	Admission Date	Discharge Date
Surgery <input type="checkbox"/> No <input type="checkbox"/> Yes	Surgery Type	Date
Specialist <input type="checkbox"/> No <input type="checkbox"/> Yes	Specialist Name	General Anesthesia <input type="checkbox"/>
Specialty	Expected/Actual Delivery Date	Delivery Type

Treatment Plan (ie. medication & dosage; physiotherapy, frequency, & duration; upcoming test/referral/procedure incl. types & dates)

Compliance Yes No, Describe Above

Patient not Competent to Manage Own Affairs

Note: If expedited diagnostic or specialist assessment is recommended, please enclose the requisition. If cognitive behavioural therapy (CBT) recommended, enclose the psychological treatment referral so care can be coordinated on an expedited basis.

If patient is able to return to work with modified hours or duties, please provide date and recommendations for return to work

Next Assessment Date	Frequency of Visits	Actual or Estimated Return to Work Date – Own Job
----------------------	---------------------	---

Please attach any additional information that would give us a better understanding of the patient's condition or treatment needs.

Declaration

I certify that the above information is true, correct, and complete.

Physician's Name	Telephone Number
Physician's Address	Fax Number
Physician's Signature	Date