

Before mailing this form, check that:

- All information has been provided. Failure to provide all information may delay this claim.
- Form has been dated and signed by the member, union and physician

You must submit this claim to BC Life by the policy claiming deadline.

Disability & Life Claims Department
PO Box 7000 Vancouver BC V6B 4E1

Telephone 604 419-8040
Toll-free 1 888-275 4672
Fax 604 419-8055

Member Statement

Last Name		First Name		Policy Number		Identification Number	
Date of birth (mm/dd/yyyy)		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male				Phone number (ten digits)	
Address/city/province/postal code							
Occupation and duties						Average weekly salary	
Name of your most recent employer				Date hired (mm/dd/yyyy)		Last day worked (mm/dd/yyyy)	
Employer's address/city/province/postal code							
Have you registered for work with your union local? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date registered (mm/dd/yyyy)		Have you received or do you plan to receive EI benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount per week \$	
Is disability due to an occupational injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has a claim been filed with Workers Compensation (WCB) <input type="checkbox"/> Yes <input type="checkbox"/> No		Date filed (mm/dd/yyyy)		Status/result of WCB claim:	
Are you entitled to receive any income from other income replacement plans or sources? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, amount of other income \$		Name of company / details			
Complete if you have holidays scheduled or any type of leave during this disability period.		<input type="checkbox"/> Holidays <input type="checkbox"/> Bereavement		From (mm/dd/yyyy)		To (mm/dd/yyyy)	
		<input type="checkbox"/> Maternity <input type="checkbox"/> Leave of Absence					
Date you became unable to work (mm/dd/yyyy)		Date you first saw a doctor after you stopped working (mm/dd/yyyy)		Date you were first able to return to work (mm/dd/yyyy)			
Full name of physician						Phone number (ten digits)	
Physician's address/city/province/postal code							

Accident Information (if your claim is the result of an accident)

Date of accident (mm/dd/yyyy)		Time of accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Where did the accident happen? <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Elsewhere		If elsewhere, specify	
Describe how the accident happened							

Member Consent & Declaration

I certify the above facts are true and complete and authorize the release to British Columbia Life & Casualty Company (BC Life) all medical and other information requested to assess my claim for Short Term Disability benefits.

Signature		Date (mm/dd/yyyy)
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Union Authorization

Group	Division	Sub-Division	Class	Effective date of insurance (mm/dd/yyyy)
The member named above is a member of:		Union name		Local number
Remarks				
Authorized official's signature		Title	Date (mm/dd/yy)	

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Accurate assessment of this claim depends on each question being answered in full.
The patient is responsible for any charges made for the completion of this form.

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Attending Physician's Statement

Patient's name		Date of birth (mm/dd/yy)	
Primary diagnosis			
Secondary diagnosis (if applicable)			
How does the present condition affect the patient's ability to work (e.g. restrictions, limitations, proposed surgery)?			
Nature of treatment (e.g. medication prescribed, type of treatment, frequency)			
Were diagnostic studies made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of studies (mm/dd/yy)	Type of studies and findings	
If the patient was referred to you, give name of referring physician		If you have referred the patient to a specialist, give name(s) of physician and speciality	
Date you first treated the patient for this condition	(mm/dd/yy)	Date of last treatment	(mm/dd/yy)
If hospitalized: Name of hospital		Dates confined to hospital: From (mm/dd/yy)	To (mm/dd/yy)
What surgery, if any, was performed?			Date of surgery (mm/dd/yy)
If disability due to an accident, date the accident occurred:	(mm/dd/yy)	If claim was reported to WCB or WorkSafe BC, or in any way related to patient's occupation, give details	
If the patient is receiving a pension, give details of pensionable disability			
Dates of visits other than procedures named above. <i>Check all that apply.</i>			
	Month	Year	1 2 3 4 5 6 7 8 9 10 11 12 23 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Office			
Hospital			
Home			
To the best of your knowledge, indicate the period your patient has been unable to work at his/her own occupation as a result of the present condition.		From (mm/dd/yy)	To (mm/dd/yy)
If your patient is still unable to work, give the approximate date he/she should be able to return to work:		(mm/dd/yy)	or, from today, estimated number of weeks to recovery
Prognosis			
Remarks (any details which you feel would be helpful)			
Physician's name (print)		Address	Telephone
Speciality	MSC number	Signature	Date signed (mm/dd/yy)

Patient's Authorization

<i>I authorize the release to British Columbia Life & Casualty Company (BC Life) all medical reports and other information requested to assess my claim for Short Term Disability benefits.</i>	
Signature	Date signed (mm/dd/yy)