PACIFIC BLUE CROSS®

Union Taxable Plan Short Term Disability Claim Form

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 Pacific Blue Cross by the policy claiming deadline.

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 ☐ Female ☐ Male	Phone number (ten digits)	Email address

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? ☐ Yes ☐ No	Date registered (mm/dd/yyyy)	Have you received or do you plan to receive EI benefits? ☐ Yes ☐ No	Amount per week $

Is disability due to an occupational injury or illness? ☐ Yes ☐ No	Has a claim been filed with Workers Compensation (WCB) ☐ Yes ☐ 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? ☐ Yes ☐ 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. ☐ Holidays ☐ Bereavement ☐ Maternity ☐ Leave of Absence	From (mm/dd/yyyy)	To (mm/dd/yyyy)

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 ☐ a.m. ☐ p.m.	Where did the accident happen? ☐ Work ☐ Home ☐ 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 Pacific Blue Cross all medical and other information requested to assess my claim for Short Term Disability benefits.

Signature	Date (mm/dd/yyyy)

Union Authorization

Group	Division	Sub-Division	Class	Effective date of insurance (mm/dd/yyyy)
903638	1		1	

The member named above is a member of:	Union name	Local number
	IUPAT DISTRICT COUNCIL 38 HEALTH AND WELFARE TRUST FUND	

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.

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? ☐ Yes ☐ 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 disability is related to pregnancy give expected date of delivery	(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. *Check all that apply*.

	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 authorize the release to Pacific Blue Cross all medical reports and other information requested to assess my claim for Short Term Disability benefits.

Signature	Date signed (mm/dd/yy)