IUPAT DISTRICT COUNCIL #38
DC38
Health & Welfare
7621 KINGSWAY, BURNABY, BC V3N 3C7
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Information and Benefits Schedule

NON-OCCUPATIONAL
SHORT TERM DISABILITY BENEFIT
(WEEKLY WAGE INDEMNITY)

Effective March 23, 2020 / Revised April 14, 2023

PLEASE READ THIS BROCHURE

To qualify for Short Term Disability (STD) coverage, members must:

Be covered on the FULL H&W Plan on the date of disability, and
have had coverage with DC38 Health & Welfare Trust Fund for the 8 consecutive months immediately preceding the date of disability, whether covered on the Full Plan and/or the Partial Package and/or the Mini Plan, or any combination of the these Plans. There cannot be any breaks in coverage for the 8 months immediately preceding the date of disability.

A. BENEFITS

The weekly benefit is **$573.00**.
Benefits are paid by B.C. Life & Casualty Company (BC Life) under **Group: 903638.**

This is a sickness and *non-occupational* injury benefit and provides for the payment of $573.00 per week for a maximum of 51 weeks (Combined with EI) for any one period during which you are totally disabled and prevented from performing work of any kind solely as a result of a *non-occupationa*l accident or illness.

You must be covered by the plan on the first day of disability in order to receive benefits. Benefits are paid pro-rata on the basis of a five day week.

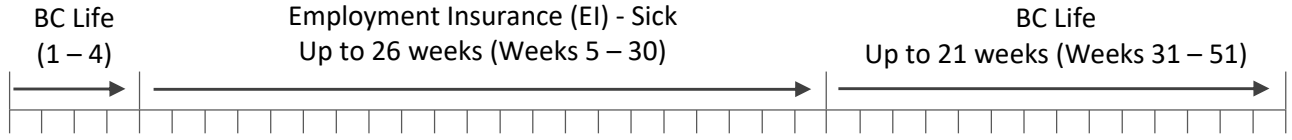
The STD benefit is integrated with **Employment Insurance (EI) SICK BENEFITS** (Four week carve out), and is therefore split into three separate benefit periods:

1. **BC Life covers (up to) the first 4 weeks of disability.**
   The date benefits commence will depend on the type of disability:
   Non-Occupational Accident: From the 1st day of disability resulting from an accident to the 28th day (28 days), or
   Hospitalization: From the 1st day of Hospitalization to the 28th day (28 days), or
   Non-Occupational Sickness: From the 4th day up to and including the 32nd day (28 days) of disability resulting from illness not requiring hospitalization.
2. **Employment Insurance (EI) would then cover the next 26 weeks (if necessary).**
3. **B.C. Life would then cover the remaining 21 weeks (if you are still disabled).**

* The maximum period payable from both B.C. Life and EI is 51 weeks.

NOTE: In order to qualify for EI sick benefits you must meet EI eligibility requirements. Claims must be filed for EI sick benefits **once your 4 weeks of STD has been paid and if you are still unable to return to work.** If you are rejected by EI, B.C. Life will cover you for the period not covered by EI provided you are still disabled under the terms of the Short Term Disability Plan. Pacific Blue Cross Work and Wellness (PBC) must be provided with a letter of rejection from EI.

Maximum Benefit Timeline:



NOTE: Short Term Disability payments to you are taxable income and must be reported for income tax purposes. B.C. Life will provide you with a T4A for the total amount of benefits paid to you.

B. CLAIMING FOR BENEFITS

1. Contact your medical doctor immediately upon becoming disabled; the date of your visit to your doctor determines the starting date of your claim.
2. You must complete the front of the attached claim form.
3. Ask your medical doctor to complete the Physician's Statement on the back of the STD form. Your Physician may charge a fee for this service which you must pay. BC Life does not reimburse this fee.
4. Sign both sides of the form - incomplete forms may delay payment.
5. **IMPORTANT:** it is your responsibility to deliver or have the claim form sent to the Administrator at the **Union HEALTH & WELFARE Office** for authorization. If you send or fax it directly to BC Life, YOUR CLAIM WILL NOT BE PAID.

   Claims will be assessed by B.C. Life and when approved, you will receive your benefit cheques by mail at your home address, or if you have registered for direct deposit within your Pacific Blue Cross member profile, it will be deposited directly to your bank account.

   Claims should always be sent in within 30 days of commencement of disability unless special circumstances prevent you from doing so.

   Benefits will be paid when a member is under the full time care of a physician and/or surgeon. Where there is any doubt as to the validity of a claim, B.C. Life reserves the right to obtain a second medical opinion from a physician and/or surgeon of their choice.

   Benefits can also be paid for a period of up to six weeks for any one disability on the signature of a chiropractor. For benefits beyond six weeks the signature of a medical doctor will be required.

NO FAULT, UNINSURED OR HIT AND RUN ACCIDENTS:

No benefits will be paid to members who have a right or claim to indemnity under Section 20 or 24 of the Insurance (Motor Vehicle Act) or a right or claim to receive accident benefits under Part 7 of the Insurance (Motor Vehicle Act) Revised Regulation (1984).

C. THIRD PARTY LIABILITY

With the exception of accidents described in the previous paragraph, benefits will be paid for disabilities for which a third party is or may be in whole or in part legally liable only where the member agrees in writing, to do the following:

Take all steps to recover from the Third Party, the total of the benefits advanced, including without limitation, directing the member's lawyer to repay to B.C. Life the full amount of the benefits directly from any monies received pursuant to any judgement or settlement

Pay all legal fees and disbursements incurred in pursuing the action against the Third Party;

Repay to B.C. Life the full amount of the benefits advanced in the event the claim against the Third Party is abandoned or settled without the written consent of B.C. Life;

Enter into a Reimbursement Agreement with B.C. Life setting out the terms and conditions for repayment of the Benefits;

Consent to the release by the Third Party or Insurance Corporation of BC of all information in their possession relating to the member's claim.

D. RECURRENCE OF FORMER AILMENTS

The maximum payable for one disability period is 51 weeks. If you return to work (with the consent of your medical doctor) and are at work for two consecutive weeks and again become disabled, it will be considered a new disability period.

E. LIMITATIONS AND EXCLUSIONS

No benefits will be paid for periods of disability resulting from:

Occupational accidents or illnesses; or

Self-inflicted injuries and diseases (with the exception of alcoholism or drug addiction); or

Injuries or diseases resulting from war, or participation in a riot, or arising while serving as a member of any armed force; or

The commission by the member of any unlawful act including an offence under the Criminal Code of Canada.

A pregnancy related illness:

- during any period of formal Maternity Leave taken by the member pursuant to Provincial or Federal Law or pursuant to mutual agreement between the member and her employer; and
- During the period commencing with the tenth week prior to the expected week of maternity confinement and ending with the sixth week after such confinement; and
- During any period in which the member is paid Employment Insurance Maternity Benefits.

No benefits will be paid for any period for which the person has, or will receive Vacation Pay or an annual vacation or for any period of disability that commenced prior to the effective date of coverage.

F. OTHER INSURANCE COVERAGE

If you have other insurance coverage, you may not draw more, in all benefits, than you would normally earn. In such an event, your benefits from this Plan would be reduced proportionately.

G. OVERPAYMENT OF BENEFITS

In the event of an overpayment of benefits by B.C. Life, the member will be required to reimburse B.C. Life & Casualty the full amount of the overpayment.

Please contact the Union Health & Welfare department with any questions or concerns at 604-524-8334 or 1-800-266-1527 or benefits@dc38.ca

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)

PACIFIC BLUE CROSS®

Union Taxable Plan Short Term Disability Claim Form

PO Box 7000 Vancouver BC V6B 4E1

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

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

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)