SOUTHERN INTERIOR HEALTH & WELFARE PLAN

Weekly Indemnity Benefits Claim

To avoid any delay in the processing of your claim, please be sure ALL questions are answered.

If printing this form from the internet, keep it clipped or stapled to ensure all 9 pages are submitted to Pacific Blue Cross.

NOTICE OF CLAIM must be given not later than 30 days following the first day of illness or accident and proof submitted within these 30 days.

NOTE:
A reimbursement agreement on a separate form provided by the plan must be completed in the case of claims where a full and proper WCB claim has been filed at least four weeks earlier and for which no decision has been reached or the claim disallowed.

Mailing Address:
Southern Interior Health & Welfare Plan
c/o Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

Telephone:
1 888 275-4672 *(toll free)*
604 419-8080

Fax:
604 419-8099

Administered under contract number 907704 by:
Pacific Blue Cross

0670.006.001—52-60-105 01/20 CUPE 1816

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

1. PERSONAL INFORMATION

Name (first, middle, last)		☐ Mr. ☐ Ms. ☐ Miss. ☐ Mrs.
Date of birth (mm-dd-yyyy)	Social Insurance Number	Local union number
Street address		
City	Province	Postal code
Mailing address (if different from above)		Phone number

Do you want your cheque sent to the mailing address? ☐ Yes ☐ No

2. DISABILITY INFORMATION

When did your sickness begin or accident happen? Date (mm-dd-yyyy)

Date last worked Date (mm-dd-yyyy)

On what date did disability prevent you from working? Date (mm-dd-yyyy)

Have you ever had the same or similar illness? ☐ Yes ☐ No If yes, state when and describe Date (mm-dd-yyyy)

Is disability due to an injury? ☐ Yes ☐ No If yes, what kind of injury: ☐ MVA ☐ Work ☐ At home ☐ Other

Describe how and when the injury occurred Time _____ ☐ AM ☐ PM Date (mm-dd-yyyy)

Is there any third party legal action involved? ☐ Yes ☐ No If yes, please provide lawyers' name and address:

Legal representative's name: _____

Legal representative's address: _____

Note: Reimbursement Agreement and Direction on page 5 to be completed for all claims resulting from an accident where a third party is involved.

If injury at work, has a WCB claim been filed? ☐ Yes ☐ No WCB claim number Date claim filed (mm-dd-yyyy)

Has an appeal been filed? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Does this disability relate to a previous WCB claim? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Are you receiving WCB disability benefits? ☐ Yes ☐ No If yes, provide the frequency and amount of benefits.

Frequency of benefits: _____ Amount of benefits: $ _____

Have you been hospitalized for this sickness/injury? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: _____ Admission date (mm-dd-yyyy) Discharge date (mm-dd-yyyy)

Did you visit the emergency room? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: _____ Admission date (mm-dd-yyyy) Discharge date (mm-dd-yyyy)

Please provide the following information about the family doctor who has your **medical records**.

Last name of doctor	First name of doctor		Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number			Date of next visit (mm-dd-yyyy)

Please provide the following information about **any other specialist or health care practitioner** you have seen or are scheduled to see for this condition.

Last name of doctor	First name of doctor	Speciality	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number			Date of next visit (mm-dd-yyyy)

Last name of doctor	First name of doctor	Speciality	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number			Date of next visit (mm-dd-yyyy)

Have you been referred to a specialist? ☐ Yes ☐ No If yes, provide the name and date.

Name of specialist: _____ Date (mm-yy-dddd)

Have you returned to work? ☐ Yes ☐ No If yes, when? If no, when do you expect to return? Date (mm-yy-dddd)

3. SUMMARY OF EDUCATION, TRAINING AND EXPERIENCE

School grade reached? _____ Work experience? _____

Other training, upgrading, on-the-job training or special interests:

_____

_____

Does your job require a professional certificate, licence or other qualifications? ☐ Yes ☐ No
If yes, please describe:

_____

Do you have a valid driver's licence? ☐ Yes ☐ No Class Restrictions

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

I certify that the answers given are complete, current and accurate to the best of my knowledge and belief.

I agree to refund any monies which may be due to the Southern Interior Health & Welfare Plan c/o Pacific Blue Cross as a result of payment of disability benefits from any source in accordance with the provisions of the Southern Interior Health & Welfare Plan Text.

I authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, the Workers' Compensation Board of BC/Review Board/Medical Review Panel to release to Pacific Blue Cross, the Trustees of the Southern Interior Health & Welfare Plan, Evergreen Rehabilitation Management Society and the Trustees of the IWA-Forest Industry LTD Plan, any medical or benefit payment information, or any other information or records that may be requested by Pacific Blue Cross to establish or review the validity of this claim for Weekly Indemnity benefits for the period commencing (mm-dd-yyyy): _____

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information regarding the duties and requirements of my job to establish or review the validity of this claim for Weekly Indemnity benefits.

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information required to develop a Recovery Plan and/or Return to Work Program.

I authorize the Southern Interior Health & Welfare Plan and its Agents to release to my employer information regarding my expected return to work.

I authorize the use of my Social Insurance Number for the purpose of tax reporting and for the identification and administration of my Group Benefits.

I understand the Weekly Indemnity benefit will be reduced by Income Tax withholding as required by CRA.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge I must notify Pacific Blue Cross, as the agent of the Southern Interior Health & Welfare Plan, immediately should:

a) My medical condition improve so that I would be able to work, even though I have not yet returned to work,
b) I go to work whether as an employee or as a self employed person,
c) I apply for benefits under any Workers' Compensation law or plan,
d) I apply for benefits under Canada/Quebec Pension Plan,
e) I am discharged from hospital if I am hospitalized,
f) I return to work or receive any benefits/income related to my disability,
g) I apply for benefits from the IWA-Forest Industry Pension Plan.

Employee's signature **X**		Date signed (mm-dd-yyyy)
Employee's name (please print)	Policy number 907704	Certificate number/member ID

5. REIMBURSEMENT AGREEMENT AND DIRECTION

Re: Group Contract No. 907704 between:
THE TRUSTEES OF THE SOUTHERN INTERIOR HEALTH & WELFARE PLAN and

Member name	
Address	Member ID number

PART 1 — DEFINITIONS

PLAN refers to the Southern Interior Health & Welfare Plan.
PACIFIC BLUE CROSS, *as agent for the Trustees of the PLAN*.
YOU, YOUR and the MEMBER refer to the member with whom this agreement is made.
ACCIDENT refers to the incident giving rise to your claim for benefits from the PLAN.
THIRD PARTY refers to any other person from whom you may be able to recover damages as a result of your accident.

PART 2 — THE CONTRACTUAL ARRANGEMENTS

You may have a right to recover damages from a THIRD PARTY as a result of your illness, injury or income loss which arose from an ACCIDENT which occurred on (mm-dd-yyyy): _____

Under the terms of the PLAN, you are entitled to claim Weekly Indemnity (WI) benefits in respect of some or all of the period you have been absent from work commencing (mm-dd-yyyy): _____

You agree to take all neccessary steps to recover from the THIRD PARTY the benefits which the PLAN has paid, or will in the future, pay to you. If you fail to take such steps you agree that PACIFIC BLUE CROSS may do so on your behalf, and you hereby assign to PACIFIC BLUE CROSS the right to do so in accordance with the terms of the PLAN.

If you are able to recover such benefits from a THIRD PARTY, you will repay the PLAN, c/o PACIFIC BLUE CROSS, in accordance with the terms of the PLAN. The following is a summary of the reimbursement formula:

Reimbursement Amount = (WI Benefits Paid + Gross Wage Loss Recovery) – (Lost Wages + Pro-rata Share for Legal Expenses);

- WI Benefits Paid is the amount of benefits actually paid to you up to your Settlement Date.
- Gross Wage Loss Recovery is the lesser of your Gross Settlement and your Lost Wages.
- Lost Wages is calculated by multiplying your regular job rate times 40 hours per week, times the number of weeks you receive WI benefits prior to your Settlement Date. Lost Wages will reflect scheduled increases in your hourly job rate during the disability period.
- The Pro-rata Share of Legal Expenses is your Legal Expenses multiplied by your Gross Wage Loss Recovery divided by your Gross Settlement (to a maximum of 20% of your Gross Wage Loss Recovery).
- For greater certainty, Legal Expenses includes legal fees, disbursements and all applicable taxes, including any GST or SST paid to your lawyer. In no event shall the amount allowed for the Pro-rata Share of Legal Expenses exceed 20% of your Gross Wage Loss Recovery. Disbursements and taxes paid on the legal fees are *included* in the 20% of Gross Wage Loss Recovery.

If you abandon or settle any claim you have against the THIRD PARTY without the written consent of PACIFIC BLUE CROSS, your Reimbursement Amount will equal the full amount of benefits received by you. In addition, if you wish PACIFIC BLUE CROSS to consider accepting less than full reimbursement of benefits paid, you will instruct any legal representative acting for you to give PACIFIC BLUE CROSS a full report of the details of any proposed settlement between you and the THIRD PARTY, for PACIFIC BLUE CROSS approval before any settlement is reached.

You hereby authorize and direct anyone (including ICBC) with knowledge of your ACCIDENT or any settlement relating to it to release to PACIFIC BLUE CROSS the details of any settlement you reach.

You agree to provide full details of any settlement to PACIFIC BLUE CROSS, and pay the Reimbursement Amount calculated above to PACIFIC BLUE CROSS as soon as you receive your settlement payment.

You hereby assign to PACIFIC BLUE CROSS all of your interest in any amount that is owing to you in respect of the ACCIDENT, up to the amount of the Reimbursement Amount calculated above. In particular, you irrevocably authorize, instruct and direct any legal representative who acts for you to pay PACIFIC BLUE CROSS the Reimbursement Amount out of any settlement payments received on your behalf.

The foregoing is a summary of the relevant terms of the PLAN. In the event of an inconsistency between this form and the PLAN, the PLAN prevails. You may obtain a copy of the relevant terms of the PLAN at any time at no charge.

PACIFIC BLUE CROSS, as agent for the Trustees of the Southern Interior Health & Welfare Plan (OFFICE USE ONLY)	Date (mm-dd-yyyy)
Member **X**	Witness **X**

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYER'S STATEMENT

1. EMPLOYER INFORMATION

Name		Division
Street address		
City	Province	Postal code
Contact name / Title	Phone number	Fax number

2. EMPLOYEE INFORMATION

Name (first, middle, last)	Social Insurance Number	Date of birth (mm-dd-yyyy)
Seniority date (mm-dd-yyyy)	Date last worked (mm-dd-yyyy)	

Job Classification: attach job description and physical requirements

At the beginning of absence, the employee was:

☐ A regular full-time employee

For those employees working alternative shifts, please check days off:
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

☐ Is this employee on an alternate schedule? ☐ Yes ☐ No

If yes, provide details:

☐ A regular laid-off employee

Date lay-off commenced (mm-dd-yyyy)

When laid off, this employee was entitled to _____ months continuation of lay-off coverage.

☐ A designated part-time employee

Provide details

☐ On leave of absence

From date (mm-dd-yyyy) To date (mm-dd-yyyy) Reason for leave of absence

Is leave for extended vacation or training other than apprenticeship training? ☐ Yes ☐ No

☐ On vacation with pay

From date (mm-dd-yyyy) To date (mm-dd-yyyy)

Is this claim one which might come under the Workers' Compensation act? ☐ Yes ☐ No
If yes, please submit copies of relevant WCB letters or correspondence.

Has employee returned to work? ☐ Yes ☐ No If yes, provide date of return

Date (mm-dd-yyyy)

Has employee claimed weekly indemnity benefits during the previous 4 weeks? ☐ Yes ☐ No

Have you any reason to question the validity of this claim? ☐ Yes ☐ No If yes, state reason:

_____

Who is the company contact for return-to-work issues?

Contact name Phone number

Do you have a transitional work program or disability management program? ☐ Yes ☐ No If yes, describe:

_____

Is modified work available? ☐ Yes ☐ No If yes, describe:

_____

3. SIGNATURE

I certify that the above statements are correct.

Signed for employer by **X**	Date signed (mm-dd-yyyy)

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is claiming disability benefits from Southern Interior Health & Welfare Plan. As an initial step in the entitlement process, we ask that you complete this form, providing sufficient clinical information to enable us to make an informed decision. Incomplete information may delay the payment of your patient's claim.

Instructions:

1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

1. PATIENT AUTHORIZATION

Name	Policy number	Certificate number/Member ID
	907704	

I hereby authorize the release, to Pacific Blue Cross and Evergreen Rehabilitation Management Society, of any medical information, including copies of consultation and/or office notes and test/investigative reports, with respect to this claim for the period commencing (mm-dd-yyyy): _____

Patient's signature	Date signed (mm-dd-yyyy)
X	

2. ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS

Primary Diagnosis: _____

Secondary diagnoses or complications:

_____

Please describe any functional impairment or restrictions for your patient's ability to work:

_____

_____

Are these ☐ temporary or ☐ permanent? If temporary, expected duration: From (mm-dd-yyyy) To (mm-dd-yyyy)

CLINICAL INFORMATION

What date did symptoms first appear/accident happen? Date (mm-dd-yyyy)

How long has your patient had this condition? _____

Condition is due to ☐ Illness ☐ Injury ☐ Work-related ☐ MVA ☐ Other (specify below):

_____

What are your patient's current symptoms? _____

What are your clinical findings? _____

What are the dates of the first and latest visits for this condition? Date of first visit (mm-dd-yyyy) Date of latest visit (mm-dd-yyyy)

Dates of Visits (✔) exclusive of above procedures

PLACE	MONTH	YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OFFICE																																	
HOSPITAL																																	

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is: ☐ Ambulatory ☐ Bed confined ☐ Home confined
☐ Ambulatory with assistive devices ☐ Hospital confined

What is your patient's current height/weight/dominant hand? Current height ____ Current weight ____ Dominant hand ☐ Left ☐ Right

If patient is hypertensive, provide the last 3 blood pressure readings:

Reading: ____ Date (mm-dd-yyyy) | Reading: ____ Date (mm-dd-yyyy) | Reading: ____ Date (mm-dd-yyyy)

If psychiatric disorder, provide current GAF Score: _____

If cardiac disorder, provide American Heart Association Functional Classification: ☐ Class I (No limitation)
☐ Class II (Slight limitation) ☐ Class III (Marked limitation) ☐ Class IV (Complete limitation)

DIAGNOSTIC INVESTIGATIONS

Please enclose copies of current consultation and diagnostic investigative reports (X-rays, scans, laboratory data, etc.)

TREATMENT

Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN OR TO BE SEEN
		(mm-dd-yyyy)
		(mm-dd-yyyy)

Current medications:

NAME	DOSAGE	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Other forms of treatment or therapies:

TYPE	EXPECTED DURATION	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Hospitalizations:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

Emergency Room treatment:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

Treatment Response ☐ Recovered ☐ Improved ☐ No Change ☐ Retrogressed Comments:

Is your patient following the recommended treatment program? ☐ Yes ☐ No If no, please elaborate:

Details of any **proposed** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

LICENCE RESTRICTION

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition? ☐ Yes ☐ No

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification? Date (mm-dd-yyyy)

Would your patient be a suitable candidate for:

Vocational Rehab Program? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Modified work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Work hardening? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Graduated return to work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition. From (mm-dd-yyyy) To (mm-dd-yyyy)

If still unable to work, give approximate date patient should be able to return to work. Date (mm-dd-yyyy) or Estimated number of weeks before possible return to work

REMARKS

Please include any additional comments/information that you believe may help in the assessment of this claim:

3. SIGNATURE

Name of attending physician (please print)	Specialty	Phone number
Address (number, street, city, province, postal code)		Fax number
Signature **X**		Date signed (mm-dd-yyyy)

PACIFIC BLUE CROSS®

Southern Interior Health & Welfare Plan

Here are the steps in a Weekly Indemnity (WI) claim process:

Steps

1 Paperwork

Complete and prepare employee, employer, and medical forms.

To apply for benefits, you and your employer will need to send us all completed forms to prepare for assessment.

Checklist of forms:

- ✓ Employee form
- ✓ Employer form
- ✓ Attending Physician's Statement
- ✓ Direct Deposit form

Please return completed forms through one of the options below.

Fax: **604 419-8055** or **604 419-8099**
Email: **wwforms@pac.bluecross.ca**
Address: PO Box 7000,
Vancouver, BC V6B 4E1

We may not be able to process your claim until we receive all your forms, so please don't hesitate to reach out if you need help.

2 Assessment

It may take up to 5 days to make a decision once we have all required information.

For substance abuse-related disabilities, please refer to page 2.

3 Payments to you

How much will I receive?
Payment periods depend on the arrangements made with your plan administrator. The amount payable also depends on your policy. Please consult your benefits booklet or ask your employer for more information.

When will I receive payment?
Weekly Indemnity amount owing will be paid bi-weekly.

4 Developing a plan

Finding you the right support
We will work with you, your physician, and your employer to guide you through your disability.

Whether that's rehab, a return to work plan or financial aid — we will ensure you get the right support, specific to your needs.

Southern Interior Health & Welfare Plan member package

We understand that every situation and individual is unique.

It can be difficult when you're no longer able to do everything you did before your accident or illness. We are committed to working with you to give you the tools and support you need to recover and live a healthier life.

Our goal is to help you navigate the health care journey and remove any barriers, so you feel confident being your best self.

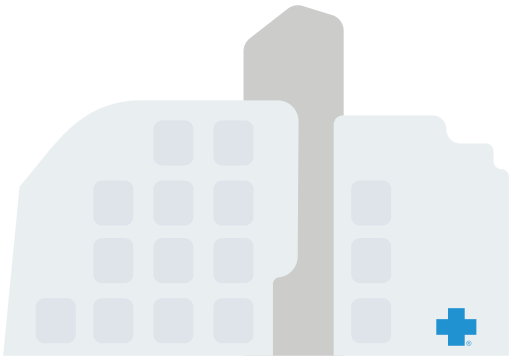
Substance abuse claims process

Benefits for substance abuse-related Weekly Indemnity claims are paid on the first day of participation in a Pacific Blue Cross approved treatment program. Treatment programs must include:

- an assessment, a treatment plan, monitoring and follow up as determined by a Substance Abuse Professional (SAP)*
- participation in early rehabilitation services offered by Evergreen Management Society

Employees must return to work or participate in a return-to-work plan once the treatment program is complete. Exceptions apply.

*A SAP is firstly qualified as a licensed physician, licensed or certified social worker, psychologist, employee assistance professional, marriage and family therapist, or an alcohol and drug abuse counselor.



Employee Responsibilities

- Provide us with complete information, including completed claim forms with supporting medical documentation throughout your claim
- Actively participate in evaluations and telephone interviews with your case manager
- Let your supervisor or manager know how you are doing and provide updates on your progress
- Help to develop a return to work plan

Pacific Blue Cross Responsibilities

- Communicate openly and completely with you
- Conduct prompt and fair assessments
- Determine your ability to function in a workplace
- Work with you and your treatment provider to develop healthcare and return to work plans
- Partner with you, your physician, Evergreen and employer to ensure a safe return to work

Employer Responsibilities

- Provide accurate information to Pacific Blue Cross including insurance details and job information
- Keep open and continuous communication with you while you are away from work
- Be actively involved in helping you return to work

Questions?
Give us a call or email us for more details.

Direct: **604 419-8040**
Toll-free: **1 877 722-2583**
Email: **wwforms@pac.bluecross.ca**

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