

# Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan

Funds Administrative Service Inc.  
 9<sup>th</sup> Floor, 9707-110 Street  
 Edmonton, AB T5K 3T4  
 Phone (780) 452-5161  
 Toll Free 1-800-770-2998

Policy #XC-6128

## WEEKLY DISABILITY BENEFITS STATEMENT

<b>Member Information</b>		Local Union No		<b>Please Check Here <input type="checkbox"/> if this is a Change of Address</b>			
Name (Last)		(First)		Sex (circle)		Date of Birth	
				M	F	M	D
Address (Street)		Social Insurance Number					
(City)		Prov	Postal Code			Telephone Number	

Date Employed			Last Day Worked			<input type="checkbox"/> AM  <input type="checkbox"/> PM	Was more than half day worked? <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, how many hours? _____
M	D	Y	M	D	Y		
Date Disability Caused Lost Time			Date Returned to Work			Has claimed been filed with UIC Sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No  Is illness or injury due to occupational causes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
M	D	Y	M	D	Y		

Has a claim been filed with Worker's Compensation Board?  No  Yes – If Yes, provide Claim No: \_\_\_\_\_

Have you (or will you) applied/apply for any benefits from any other sources (including pension benefits)?  Yes  No

If Yes, what is the amount of the benefit received? \_\_\_\_\_

A copy of your tax return may be required at the request of the Administrator.

**IN CASE OF ACCIDENT:**

Last Day Worked			<input type="checkbox"/> AM  <input type="checkbox"/> PM	Where did accident occur? (i.e. Home, School, Job Site, Other (specify))			
M	D	Y					
How did accident occur?				What was claimant doing at time of accident?			
Nature of injuries - Specify							

I hereby authorize any healthcare provider, my plan administrator, insurance companies, other organizations, or benefit service providers working with Maritime Life to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Member

