UNITED FISHERMEN'S BENEFIT FUND

#4 – 830 14th Ave. Campbell River, B.C. V9W 4H4 • 778 645 0578 • Benefits@ufawu.org

TOTAL DISABILITY CLAIM

CLAIMANT'S STATEMENT

NAME ______________________ PHONE ______________________

ADDRESS ____

DATE OF BIRTH ______________________ SOCIAL INSURANCE NO. ______________________

MEMBER OF: UFAWU-UNIFOR ❑ NBBC ❑

FISHING YOU HAVE DONE IN THE PAST FIVE YEARS:

YEARS	TYPE OF FISHING	NAME OF BOAT	COMPANY, YOU DELIVERED YOUR CATCH

WHAT DATE DID YOU LAST WORK? ______________________

WHEN DID YOU BECOME TOTALLY DISABLED? ______________________

WHAT IS THE NATURE OF YOUR DISABILITY? ______________________

____

HOW LONG DO YOU EXPECT TO BE TOTALLY DISABLED AND UNABLE TO WORK? ______________

____

DO YOU BELIEVE THAT YOU ARE PERMANENTLY DISABLED FROM WORKING (PLEASE EXPLAIN) ______

____

DO YOU INTEND TO RETRAIN OR APPLY FOR OTHER WORK? ______________________

PLEASE LIST ANY OTHER PENSION OR DISABILITY BENEFITS THAT YOU HAVE BEEN OR MAY BECOME ELIGIBLE FOR: ______________________

PLEASE LIST ALL PHYSICIANS AND SURGEONS WHO HAVE BEEN CONSULTED DURING YOUR PRESENT DISABILITY:

DR.'S NAME	ADDRESS	PHONE

DECLARATION OF CLAIMANT

I HEREBY MAKE CLAIM TO THE BOARD OF TRUSTEES OF THE UNITED FISHERMEN'S BENEFIT FUND IN ACCORDANCE WITH THE RULES OF THE FUND AND CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE THAT THE DECISION OF THE TRUSTEES UPON THIS CLAIM WILL BE ACCEPTED BY ME AS FINAL. I UNDERSTAND THAT PAYMENT OF THE CLAIM MAY TAKE UP TO TWO YEARS.

DATED: ______________________ SIGNED: ______________________

PLEASE SEND A COPY OF YOUR BIRTH CERTIFICATE OR OTHER PROOF OF AGE WITH THIS CLAIM.

DECLARATION OF CLAIMANT

PLEASE COMPLETE THIS STATEMENT AND RETURN THE FORM TO YOUR PATIENT. ANY FEES FOR COMPLETION OF THIS FORM ARE NOT THE RESPONSIBILITY OF THE UNITED FISHERMEN'S BENEFIT FUND.

PATIENT'S NAME ______________________________ AGE __________

1. WHEN DID THE PRESENT ILLNESS BEGIN OR INJURY OCCUR? ______________________________
2. WHEN WAS THE PATIENT DISABLED FROM REGULAR WORK? ______________________________
3. DIAGNOSIS (PLEASE DESCRIBE ANY PERMANENT DISABILITY OR CONDITION) ______________________________
4. DATE OF FIRST TREATMENT ______________________________

   DATE OF LAST EXAMINATION ______________________________
5. FREQUENCY OF VISITS ______________________________
6. PLEASE INDICATE THE PATIENT'S PROGRESS:

   RECOVERED ❑ IMPROVED ❑ UNIMPROVED ❑ RETROGRESSED ❑
7. WHEN DO YOU THINK THE PATIENT WILL BE FIT TO RETURN TO REGULAR WORK?

   APPROXIMATE DATE: ______________ 20 _____ INDEFINITE ❑ NEVER ❑
8. WILL THE PATIENT BE ABLE TO DO OTHER WORK? (IF "**YES**", PLEASE EXPLAIN) ______________________________
9. IS THE PATIENT, TOTALLY AND PERMANENTLY DISABLED AND THEREBY PREVENTED FROM ENGAGING IN ANY GAINFUL EMPLOYMENT? ______________________________

NAME OF PHYSICIAN ______________________________ PHONE ______________

ADDRESS: ______________________________

DATED ______________ SIGNED ______________________________