UNITED FISHERMEN'S BENEFIT FUND

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

CLAIM FOR WEEKLY INDEMNITY BENEFITS

INSTRUCTIONS TO CLAIMANT- After you have filled out and signed the Claimant's Statement, your doctor must complete the Attending Physician's Statement.

NAME _____ (FIRST) _____ (INITIAL (S)) _____ (LAST)

ADDRESS _____ POSTAL CODE _____

DATE OF BIRTH _____ (MM/DD/YYYY) SOCIAL INSURANCE NUMBER _____ ☐ MALE ☐ FEMALE

PHONE _____ CELL _____ PBC NUMBER _____

MEMBER OF: ☐ **UFAWU-Unifor** ☐ **NBBC**

DATE YOU LAST WORKED _____ (MM/DD/YYYY) DATE OF DISABILITY _____ (MM/DD/YYYY)

BOAT FISHED ON WHEN DISABLED _____ TYPE OF FISHING ENGAGED IN _____

GIVE CAUSE OF DISABILITY (if due to an accident, PLEASE PROVIDE DETAILS): _____

_____

_____

_____

IF YOU HAVE RETURNED TO WORK, PLEASE GIVE DATE: _____ (MM/DD/YYYY)

IF YOU HAVE NOT RETURNED TO WORK, WHEN DO YOU EXPECT TO? _____ (MM/DD/YYYY)

HAVE YOU FILED, OR DO YOU INTEND TO FILE A CLAIM FOR BENEFITS UNDER THE:

WORKSAFE BC ACT: (YES or NO) _____ or EMPLOYMENT INSURANCE ACT: (YES or NO) _____

All information is true and complete. I consent to the disclosure of this personal information to UFBF, to other insurance companies and to other authorized third parties for the purpose of administering my plan, assessing, and providing benefit coverage or when required by law.

Date _____ (MM/DD/YYYY) Claimant Signature _____

ATTENDING PHYSI CIAN'S STATEMENT - **Please complete this form and return it 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: _____

NATURE OF SICKNESS OF INJURY (Please describe, also list complications as well, if any):

_____

_____

DID THIS SICKNESS OR INJURY ARISE OUT OF PATIENTS' EMPLOYMENT? (YES or NO): _____

IF YES, PLEASE EXPLAIN:

_____

_____

_____

NATURE OF SURGICAL of OBSTETRICAL PROCEDURE (describe fully IF ANY):

_____

_____

_____

DATES OF FIRST TREATMENT: _____
MM/DD/YYYY

THIS PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM: _____ **TO:** _____
MM/DD/YYYY MM/DD/YYYY

IF STILL DISABLED, PLEASE GIVE **APPROXIMATE** DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: _____
MM/DD/YYYY

IS THE PATIENT SCHEDULED FOR RE-ASSESSMENT? _____ IF YES, DATE _____
MM/DD/YYYY

REMARKS:

_____

_____

_____

NAME OF PHYSICIAN _____ PHONE _____

ADDRESS _____

DATE _____ PHYSICIANS SIGNATURE _____
MM/DD/YYYY

All claims delivered to: Benefit Director, United Fishermen & Allied Workers Union-Unifor, #4 - 830 14th Ave Street Campbell River BC. V9W 4H4