

# INDUSTRIAL CARPENTERS BENEFIT PLAN

SUITE 300 - 2806 KINGSWAY, VANCOUVER, B.C. V5R 5V1  
 PHONE 604-438-2434 TOLL FREE 1-877-411-2806 FAX 604-438-5348 WEBSITE www.cwbp.ca

## WAGE INDEMNITY CLAIM FORM

1. SOCIAL INSURANCE NUMBER <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>			2. MEMBER NUMBER <input style="width: 100%; height: 20px;" type="text"/>		3. MEMBER'S NAME (Please print) <input style="width: 100%; height: 20px;" type="text"/>								
4. Mailing address (give number, street and city or town) <input style="width: 100%; height: 20px;" type="text"/>					POSTAL CODE <input style="width: 50px; height: 20px;" type="text"/>	5. DATE OF BIRTH <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">YR.</td> <td style="width: 33%;">MO.</td> <td style="width: 33%;">DAY</td> </tr> <tr> <td><input style="width: 100%; height: 20px;" type="text"/></td> <td><input style="width: 100%; height: 20px;" type="text"/></td> <td><input style="width: 100%; height: 20px;" type="text"/></td> </tr> </table>		YR.	MO.	DAY	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
YR.	MO.	DAY											
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>											
6. Date you first became totally disabled <input style="width: 100%; height: 20px;" type="text"/>		7. Describe your illness or how the accident happened. <input style="width: 100%; height: 20px;" type="text"/>			8. PHONE NUMBER <input style="width: 100%; height: 20px;" type="text"/>								
9. FULL Name and address of your most recent employer <input style="width: 100%; height: 20px;" type="text"/>						10. Date last worked <input style="width: 100%; height: 20px;" type="text"/>							
11. Date first seen by a doctor <input style="width: 100%; height: 20px;" type="text"/>			12. Full name and address of doctor(s) (Please print) <input style="width: 100%; height: 20px;" type="text"/>										
13. <b>EMPLOYMENT INSURANCE INFORMATION -</b> This section must be completed.													
(A) Have you applied for employment benefits Yes <input type="checkbox"/> No <input type="checkbox"/>		(B) If yes, regular? <input type="checkbox"/> or sickness? <input type="checkbox"/>											
(C) If receiving benefits, amount per week \$ <input style="width: 100px;" type="text"/>		(D) Benefits received from <input style="width: 50px;" type="text"/> 20__ to <input style="width: 50px;" type="text"/> 20__		(E) EI office <input style="width: 100%; height: 20px;" type="text"/>									
(F) If rejected for employment benefits, date rejected <input style="width: 100px;" type="text"/> 20__		(G) Reason rejected <input style="width: 100%; height: 20px;" type="text"/>											
14. <b>WORKERS' COMPENSATION BOARD INFORMATION -</b> This section must be completed													
(A) Is disability due to an occupational sickness or injury Yes <input type="checkbox"/> No <input type="checkbox"/>		(B) Has claim been filed with Workers' Compensation Board Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give date filed <input style="width: 100px;" type="text"/> 20__		(C) Benefits received from <input style="width: 50px;" type="text"/> 20__ to <input style="width: 50px;" type="text"/> 20__									
(D) If rejected by WCB, date rejected <input style="width: 100px;" type="text"/> 20__		(E) Reason rejected <input style="width: 100%; height: 20px;" type="text"/>											
(F) If rejected by WCB, is an appeal being filed Yes <input type="checkbox"/> No <input type="checkbox"/>		(G) If an appeal is in process, union local and representative assisting with appeal: Union local <input style="width: 50px;" type="text"/> Name <input style="width: 100px;" type="text"/>											
15. <b>ACCIDENT INFORMATION - Complete only if claim is a result of injuries sustained in an accident:</b>													
Date of accident <input style="width: 100%; height: 20px;" type="text"/>		Time of accident at <input style="width: 50px;" type="text"/> o'clock (p.m./a.m.)		Was the work being done for an employer at the time of the accident Yes <input type="checkbox"/> No <input type="checkbox"/>		If not at work, where did accident happen? <input style="width: 100%; height: 20px;" type="text"/>							

### AUTHORIZATION OF PATIENT

I hereby certify the facts above are a true report and on the basis thereof request benefits to which I may be entitled. I agree that any benefits or payments made by the CWBP shall be on the basis of these representations and without prejudice to the CWBP rights.

I hereby authorize the release to the Carpentry Workers' Benefit Plan of B.C. complete written reports, covering the diagnosis, treatment and prognosis and all other information which may be required as a result of my claim for wage indemnity benefits.  
 I also accept the responsibility of having my Doctor complete the Physician's statement on the reverse side of this form.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_ 20\_\_

### PLEASE NOTE

**CLAIM FORM MUST BE FULLY COMPLETED - ALL QUESTIONS MUST BE ANSWERED. CLAIM MUST BE SUBMITTED AS SOON AS POSSIBLE AND WITHIN 30 DAYS OF BECOMING DISABLED.**

AFTER THIS FORM IS FILLED OUT PLEASE MAIL TO:

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## ATTENDING PHYSICIAN'S STATEMENT

PLEASE PRINT CLEARLY

1. Patient's Name	2. Birthdate
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3. Patient's Address
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4. Diagnosis and cause of disability
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5. Were diagnostic studies made	6. Findings
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7. What operation, if any, was performed?	8. Date of surgery
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9. Name of referring doctor
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10. Date you first treated patient for this condition	11. Date of last treatment
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12. If hospitalized, name of hospital	13. Dates confined to hospital From _____ 20__ to _____ 20__
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14. If disability is due to injuries in an accident, give date patient claims accident occurred.	15. If claim was reported to W.C.B. or disability is in any way related to patient's occupation, please explain.
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16. If patient is receiving a pension, please give details of pensionable disability.
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17. 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																																				
	HOME																																				

18. Patient has been totally disabled (prevented from performing every and any duties in connection with his occupation).
A From _____ 20__ To _____ 20__
B If still totally disabled give approximate date patient should be fit to return to work _____ 20__

19. Is patient confined to home? (If yes, dates) _____ inclusive _____ 20__
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20. Describe any other disease or infirmity affecting present condition:
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21. Prognosis
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Date	Doctor's Signature	M.D.	Doctor's Number
Doctor's Address	Phone Number		

**IT IS THE CLAIMANT'S RESPONSIBILITY TO ARRANGE FOR THE COMPLETION OF THIS FORM.**