Mail all claim forms to:
GLOBAL BENEFITS
901-191 THE WEST MALL
TORONTO ON M9C5K8

SEIU LOCALS 1 & 2 BENEFIT TRUST

APPLICATION FOR DISABILITY BENEFITS

EMPLOYEE STATEMENT OF CLAIM				
Employer	Employer location (city and province)			
Employee's Last Name	Employee's First Name	Initial	Employee Identification No. Social Insurance Number	
Employee's Address: Number / Street/ Apt. No.	City	Province	Postal Code	
Home Phone ( ) _____ - _____	Cell Phone ( ) _____ - _____	Date of Birth _____/_____/_____ Day Month Year		
Occupation	Is illness or injury due to occupational causes?			
Please advise if payment has been made (or will be made) to employee for any vacation days or holidays during Disability Period being claimed for: If "Yes", please advise date/s involved:	_____ ☐ Yes FROM: _____	_____ ☐ No TO: _____		
Basic Weekly Earnings: $_____				

COMPLETE ONLY IN CASE OF ACCIDENT:

Date and Time Day _____ Month _____ Year _____ ☐ AM ☐PM	Where did accident occur ? (i.e. Home, Business, Other (specify)
How did accident occur ?	What was claimant doing at time of accident ?
Nature of injuries – Specify	

IMPORTANT: Please mark off NORMAL weekly working days

☐ Mon. ☐ Tue. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Last Day Worked: _____

Signature of Employee: _____	**Date:** _____/_____/_____ Day Month Year

ATTENDING PHYSICIAN'S STATEMENT
Please return completed form to your patient

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**

Part 1: PATIENT AUTHORIZATION	**POLICY NO:**
Name	Date of Birth _____/_____/_____ Day Month Year
I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim.	
Patient's Signature:	**Date:** _____/_____/_____ Day Month Year

Part 2 : ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis of present condition
   (a) Primary _____
   (b) Additional conditions or complications which might affect duration of absence from work _____
   _____

2. To the best of your knowledge (a) Indicate when symptoms first appeared or accident happened _____/_____/_____ Day Month Year	(b) Has patient had same or similar condition ? ☐ No ☐ Yes, please state when and describe
3. Is condition due to injury or sickness arising out of patient's employment ☐ Yes ☐ No ☐ Unknown	4. If patient is/was pregnant indicate date or expected day of confinement. _____/_____/_____ Day Month Year
5. Date of hospital in-patient admission _____/_____/_____ Day Month Year	6. Date of discharge _____/_____/_____ Day Month Year
7. (a) If patient was referred to you, give name of referring physician	(b) If you have referred patient to a specialist, give name(s) of physician(s)

8. (a) Date of first and all subsequent visits during present period of absence from work _____/_____/_____ Day Month Year
   (b) Were you actively supervising this patient's care during the full period
   ☐ No, comment in remarks ☐ Yes, state frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify)
9. (a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
   From: _____/_____/_____ Day Month Year To: _____/_____/_____ Day Month Year inclusive
10. (a) How does present condition affect patient's ability to work (for example restrictions, limitations, proposed surgery, etc.)
    (b) Is patient fit for trial return to work on part – time or modified basis ☐ Yes ☐ No If "Yes", indicate date
11. Do you believe patient is completed to endorse cheques and direct the use of proceeds thereof ? ☐ Yes ☐ No
12. Remarks – Please provide comments and further details which you feel would be helpful.

Name of attending physician (please print)	Specialty	Telephone No. ( ) _____ - _____
Address (number, street, city, province, postal code)		
Signature:	**Date:** _____/_____/_____ **Day Month Year**	