IUEC LOCAL 50 INSURANCE TRUST FUND

Weekly Disability Income - Statement of Claim

SECTION 1 - TO BE COMPLETED BY THE MEMBER ***(please print)***

MEMBER'S NAME (Last)	(First)
ADDRESS (Number, Street, City, Province)	POSTAL CODE

PHONE NUMBER	DATE OF BIRTH	SOCIAL INSURANCE NUMBER	GROUP PLAN NUMBER
( )	Day Month Year		

	Day	Month	Year	Time	
1. On what date were you first disabled and unable to work?					a.m. / p.m.
2. On what date do you expect to return to work?					
3. Is disability due to an accident? [ ] NO [ ] YES					
If "YES" please answer the following questions:					
a) When did it happen?					a.m. / p.m.

b) Where did it happen? [ ] at home [ ] at work
[ ] elsewhere (name place) _____

c) How did it happen? _____

4. On what date were you first treated by a physician for this disability? Day | Month | Year

5. List names and addresses of physicians who have treated you in connection with this disability.

_____ _____

_____ _____

6. Have you been hospitalized in connection with this disability? [ ] NO [ ] YES If "YES" please indicate:
Name of hospital: _____

Dates hospitalized: FROM Day | Month | Year TO Day | Month | Year

7. Are disability benefits payable from any other source as the result of this sickness or injury? [ ] NO [ ] YES
If "YES" give name of source: _____

8. The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to and use by Manion, Wilkins & Associates Ltd. of any medical or other information that my be required to establish the validity of this claim and further empower said Company to disclose any personal or claim information needed for medical case review or study. A photocopy of this release shall be as valid as the original. I authorize the use of my Social Insurance Number (SIN) for claim identification purposes only.

_____ _____

Member's Signature Date

SECTION 2 - TO BE COMPLETED BY YOUR LOCAL BUSINESS REPRESENTATIVE ***(please print)***

	Day	Month	Year	
1. On what date did this member last work?				Number of hours:
2 If Member became disabled while on Layoff, what was the date he/she was recalled and was unable to report to work?				

3 Is this disability due to an occupational sickness or injury? [ ] NO [ ] YES
If "YES" has a claim been made for Workers' Compensation benefits? [ ] NO [ ] YES

4 Member's regular earnings: $ _____ Hourly [ ] Weekly [ ]

Signed by: _____ Title: _____ Date: _____

SEND THE COMPLETED FORM TO THE TRUST FUND ADMINISTRATOR AT:

Manion Wilkins & Associates Ltd., 626-21 Four Seasons Place, Etobicoke, ON M9B 0A5 Telephone: 416-234-5044 or 1-800-263-5621