THE LABOURERS' MULTI-LOCAL WELFARE TRUST FUND OF ONTARIO

ADMINISTRATOR: GLOBAL BENEFITS

MAJOR MEDICAL AND DISABILITY CLAIM FORM

INSTRUCTIONS TO EMPLOYEE

1. Complete the Employee's statement (below) on each form sent in.
2. Your plan is integrated with Employment Insurance (E.I.) Sickness Benefits. Therefore, you must apply for both Weekly Sick Pay through the Administration Office and E.I. Sickness Benefits as soon as you become disabled.
3. All correspondence, claim forms etc. should be mailed to:
   Global Benefits
   88 St. Regis Crescent South, Toronto, Ontario M3J 1Y8
   Phone: (416) 635-6000 Fax: (416) 635-6464
4. Pharmaceutical (drugs) receipts should be attached to this form.
5. A Separate claim form is required for each disability.
6. Please show your Social Insurance Number and date of birth.

DATE OF BIRTH
D M Y

EMPLOYEE'S STATEMENT

1. Name | Address (Give Number, Street, City & Prov.) | Home Phone No.

2. Single or Married ☐ ☐ | Male or Female ☐ ☐ | Occupation | Postal Code (at home)

3. IF DEPENDENT CLAIM, please complete.
   Name of Dependent | Male or Female ☐ ☐ | Relationship | Date of Birth ___/___/___ (Day / Month / Year) | Single or Married ☐ ☐

Have you (or your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If "Yes", name of Employer and Insurance Co.

If "Yes", please indicate spouse's date of birth.

If child, indicate ☐ Student ☐ Handicapped

4. For **Weekly Disability Claim** please complete the following:
   Date last worked ___/___/___ (Day / Month / Year) ☐ A.M. ☐ P.M.

If disability was the result of an accident injury, please give details below:

(a) When did it happen? Date ___/___/___ (Day / Month / Year) Time _____ ☐ A.M. ☐ P.M.

(b) Where did it happen? At Home ☐ At Work ☐ Elsewhere ☐ **NOTE:** Claims for work related disability must be filed with the Workplace Safety Insurance Board.

If accident was at work, provide name and address of employer: _____

(c) How did it happen? _____

_____

Is this disability the result of an automobile accident? ☐ Yes ☐ No

If "Yes", you **must** file a claim for no fault insurance coverage with your insurance company.

I certify the above statements are true and I authorize all medical practitioners who may have attended or examined me or my dependent and all hospitals to furnish the Administrator: Global Benefits, all information with respect to this claim.

Date ___/___/___ (Day / Month / Year) Employee's Signature _____

As soon as you return to work, please inform Global Benefits

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ___ / ___ / ___ Signature of Member _____ Telephone Number ( ) _____