Operating Engineers of Manitoba
Local 987

Send all claims & enquiries to:
COUGHLIN & ASSOCIATES LTD
Plan Administrator
P.O. Box 764, Winnipeg, Manitoba, R3C 2L4
(204) 942 - 4438 Toll Free: 1 (888) 204 -1234

WEEKLY INCOME BENEFITS CLAIM FORM

PART 1 INSURED MEMBER'S STATEMENT

Ask your doctor to complete the Attending Physician's Statement on the reverse side. When you have completed the form and signed it, send the completed form to the Plan Administrator's Office at the above address for processing.

All information recorded on this form is confidential. Incomplete information will delay processing of this claim.

1. Name ______________________ Date of Birth ____ | ____ | ____ (Day / Mo. / Year)

2. Address ______________________

   ______________________ Postal Code ____________ Phone No. ( ) ____________

   ☐ Please check if address has changed in past 12 months.

3. **SOCIAL INSURANCE NUMBER** ☐☐☐ – ☐☐☐ – ☐☐☐

4. Group Plan Name Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund Group Policy No. 901837

5. **On what date did you last work?** ____ | ____ | ____ (Day / Mo. / Year) **and for which employer?** ______________

6. On what date do you expect to return to work? ____ | ____ | ____ (Day / Mo. / Year)

7. Is disability due to an accident? ☐ NO ☐ YES If "YES", please answer the following questions.

   (a) When did it happen? ____ | ____ | ____ (Day / Mo. / Year) Time ________ ☐ A.M. ☐ P.M.

   (b) Where did it happen? ☐ at home ☐ at work ☐ elsewhere (name place) ______________

   (c) How did it happen? ______________

8. On what date were you first treated by a physician for this disability? ____ | ____ | ____ (Day / Mo. / Year)

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

   ____

   ____

9. Have you been hospitalized in connection with this disability? ☐ NO ☐ YES

   If "YES", please indicate: Name of Hospital ______________

   Dates Hospitalized: FROM ____ | ____ | ____ (Day / Mo. / Year) TO ____ | ____ | ____ (Day / Mo. / Year)

10. Are you eligible for disability benefits from any other source as the result of this sickness or injury? ☐ NO ☐ YES

    If "YES", state the source of income:

    ☐ Worker's Compensation ☐ Employment Insurance* ☐ Automobile Insurance ☐ Other ______________

    * Have you received Employment Insurance Benefits (Regular or Special i.e. disability) during the past 52 weeks?

    If "YES", have you applied for these benefits or actually received payments? ☐ NO ☐ YES

11. The above answers are true and complete according to the best of my knowledge and belief. I authorize the use of my Social Insurance Number for identification and administration purposes and, as required by law, for Income Tax reporting. I authorize the release to and use by Coughlin & Associates Ltd., any medical or other information that may 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.

Date ______________ 19 ______ Insured Member's Signature ______________

The patient is responsible for securing this form and for charges made for its completion.

PART 2 ATTENDING PHYSICIAN'S STATEMENT Please return completed form to your patient

1. Patients Name   Date of Birth ____ Day | ____ Month | ____ Year

2. Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

3. Diagnosis of present condition
   - (a) Primary
   - (b) Secondary (if applicable)
   - (c) If appropriate — additional conditions which affect the duration of disability

4. To the best of my knowledge
   - (a) Symptoms first appeared or accident happened ____ Day | ____ Month | ____ Year
   - (b) Patient has had same or similar condition ☐ No ☐ Yes If 'Yes', state when and describe ____________

5. Date of hospital in-patient admission ____ Day | ____ Month | ____ Year

   Date of discharge ____ Day | ____ Month | ____ Year

6. If surgery performed, describe.

   Date ____ Day | ____ Month | ____ Year

7. If referred to you, give name of referring physician.

8. (a) Date of first visit for present period of disability ____ Day | ____ Month | ____ Year
   - (b) Date of latest attendance ____ Day | ____ Month | ____ Year
   - (c) Were you actively supervising the patient's care during the full period?
   - ☐ No If "No", please comment in Question 12.
   - ☐ Yes If "Yes", state frequency of visits. ☐ weekly ☐ monthly ☐ other (specify)

9. If condition is due to pregnancy, what is (or was) the expected date of confinement? ____ Day | ____ Month | ____ Year

10. (a) To the best of my knowledge, the patient has been Totally Disabled (Unable to Work at own occupation).

    From ____ Day | ____ Month | ____ Year to ____ Day | ____ Month | ____ Year Inclusive.

    (b) If still disabled, give approximate date when patient should be able to return to work ____ Day | ____ Month | ____ Year

    or, if indefinite, the estimated number of additional weeks before such return. ____additional weeks.

11. How long was or will patient be Partially Disabled? (Able to work part-time at own occupation)

    From ____ Day | ____ Month | ____ Year to ____ Day | ____ Month | ____ Year Inclusive.

12. How does present condition affect patient's ability to work? (for example restrictions, limitations, proposed surgery, etc.)

    ____

    ____

    Additional remarks ____________________

    ____

Physician's name (Please Print)	Specialty	Address

Telephone No.	Signature M.D.	Date ____ Day | ____ Month | ____ Year

I hereby authorize the release to my Insurer and my policyholder any information requested in respect of this claim.

Date ____________ Signature of Patient ____________

The patient is responsible for securing this form and for charges made for its completion.