SHOREWORKER BENEFIT FUND:

HOSPITAL BENEFIT

GENERAL INFORMATION:

A Hospital Benefit shall be payable to a member for nights hospitalized in an acute general hospital, an extended care facility or rehabilitation treatment centre approved by the Board of Trustees.

Amount of Benefit

a) The amount of the Hospital Benefit shall be fifteen **($15) dollars per night** for all nights spent in the hospital and/or daytox centre

b) Where a co-insurance is charged for treatment at a rehabilitation centre the full cost will be paid to a maximum of three thousand dollars ($3,000) per incident.

c) Honorary Members will be paid up to a lifetime maximum of five hundred and ten dollars ($510).

Payment for Rehabilitation Treatment

Where a member's admission to a rehabilitation treatment centre approved by the Board of Trustees requires payment in advance, the payment of benefit may be made directly to the treatment centre, on behalf of the member provided that the member agrees to remain for the full period of treatment.

if the member does not complete the treatment, either voluntarily or by expulsion, the portion of the benefit paid for the period the claimant did not attend treatment shall be considered an overpayment to that member.

A comfort allowance is available to members attending a rehabilitation program where coverage is provided by another carrier. The allowance will be paid at the rate of $40 per round trip for out-of-town treatment or $20 for one way.

The above is a general description, If you need help or more information:

SHOREWORKERS' BENEFIT FUND: 604 519-3634
First Floor - 326 12th Street, New Westminster, BC V3M 4H6

UFAWU-Unifor New Westminster: 604 519 3630
UFAWU-Unifor Prince Rupert: 250 624 6048 or 1-888 624 6625

SHOREWORKERS' BENEFIT FUND

1ST FLR, 326—12TH STREET, NEW WESTMINSTER, B. C. V3M 4H6 TEL: 604-519-3644 FAX: 604-524-6944

CLAIM FOR HOSPITAL BENEFIT

PATIENT'S NAME _____

ADDRESS _____

_____ PHONE _____

CITY _____ POSTAL CODE _____

SOCIAL INSURANCE # _____ DATE OF BIRTH (M/D/Y) _____

EMPLOYER _____

DATE LAST WORKED _____

All information is true and complete. I consent to the disclosure of this personal information to SWBF, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

_____ _____

DATE SIGNATURE OF MEMBER

If during your recent illness, you were hospitalized for a portion of the time, please have the next section of the form completed by the hospital. If you have any other official document (such as a receipt) that establishes the dates of your hospital stay, you can send that document to us instead of having this form signed by a hospital official. We will return any official documents to you.

PATIENT'S NAME _____

DATES OF CONFINEMENT Admission: _____, 20____ (inclusive)

Discharge _____, 20____ (inclusive)

NUMBER OF NIGHTS _____

DATED: _____ SIGNED: _____

SIGNATURE OF HOSPITAL OFFICIAL (or authorized hospital employee)

FOR: _____

NAME OF HOSPITAL