UNITED FISHERMEN'S BENEFIT FUND

WEEKLY INDEMNITY

General Information: Weekly Indemnity Benefit

Payable for weeks of fishing lost due to sickness, injury or maternity not covered by WCB or ICBC. Covers salmon fishing or other fisheries covered by contributions to the Fund.
Per week **$500**
Maximum of 10 weeks per claim

A Weekly indemnity Benefit is payable only for those calendar weeks in which there was an actual loss of earnings due to illness or injury or maternity which prevented a member from engaging in:

a) fishing or packing under the terms of an Agreement, or
b) fishing in a Non-Agreement fishery where voluntary contributions have been made.

Amount of Benefit

The amount of Weekly indemnity Benefit payable to any one member shall be $500 per week for a period not to exceed a maximum of 10 weeks

a) for each separate disability (a period of disability due to the same or related cause shall be considered the same period of disability unless each is separated by the member's return to active full time work).

Benefits shall be payable upon receipt by the Fund of a doctor's certificate stating that the member is disabled due to illness or injury.

b) any one pregnancy.

Maternity benefits will be payable for 10 weeks in which loss of earnings occur after 6 months of pregnancy until 6 months following the birth of the child. Weekly Indemnity Benefits will also be paid in the first 6 months if a doctor's certificate is provided, stating that the member concerned is unable to or should not work because of pregnancy. The maximum benefit paid will be 10 weeks for any one pregnancy.

Limitations of Benefits

Weekly Indemnity Benefits shall not be payable when a member is entitled to benefit under WCB or ICBC. However, if WorkSafe benefits are lower than the Weekly Indemnity Benefit, the fund shall top up the WorkSafe payment to the level of the amount of Benefit Fund's Weekly Indemnity.

The above is a general description of the Benefit. For more information, please contact:

United Fishermen's Benefit Fund: 604 519 3634

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

UNITED FISHERMEN'S BENEFIT FUND

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

CLAIM FOR WEEKLY INDEMNITY BENEFITS

INSTRUCTIONS TO CLAIMANT: After you have filled out and signed the Claimant's Statement, your doctor must complete the Attending Physician's Statement.

I HEREBY APPLY FOR BENEFITS ON ACCOUNT OF DISABILITY.

NAME: _____

SOCIAL INSURANCE NUMBER_____DATE OF BIRTH: _____
MONTH/DAY/YEAR

MEMBER OF: UFAWU - UNIFOR _____ NBBC _____ CANOE PASS CO-OP_____

ON WHAT DATE DID YOU LAST WORK? _____

ON WHAT DATE WERE YOU FIRST DISABLED? _____

ON WHAT BOAT WERE YOU FISHING WHEN DISABLED? _____

WHAT TYPE OF FISHING WERE YOU ENGAGED IN? _____

WHICH COMPANY WERE YOU FISHING FOR? _____

GIVE CAUSE OF DISABILITY (if due to accident, WHEN, WHERE and HOW did it happen?) _____

_____

_____

_____

IF YOU HAVE RETURNED TO WORK, PLEASE GIVE DATE: _____

IF YOU HAVE NOT RETURNED TO WORK. WHEN DO YOU EXPECT TO: _____

HAVE YOU FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER THE:

WORKSAFE BC ACT: (YES or NO) _____

OR THE EMPLOYMENT INSURANCE ACT: (YES or NO) _____

All information is true and complete. I consent to the disclosure of this personal information to UFBF, 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 CLAIMANT_____

CLAIMANT'S ADDRESS_____

_____ POSTAL CODE _____

PHONE _____

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ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME: _____ AGE: _____

NATURE OF SICKNESS OR INJURY (Describe complications, if any) _____

_____

_____

DID THIS SICKNESS OR INJURY ARISE OUT OF PATIENTS EMPLOYMENT? YES _____ NO _____

IF YES, PLEASE EXPLAIN: _____

_____

_____

_____

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY (describe fully) _____

_____

_____

_____

DATE OF FIRST TREATMENT _____ 20 _____

THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM:

_____ 20_____ through _____ 20 _____

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? _____ 20_____

Remarks _____

_____

_____

DATED: _____

SIGNED: _____MD

ADDRESS: _____

_____PHONE: _____

All Claims should be mailed or delivered to:
Benefit Fund Director
United Fishermen's Benefit Fund
1st Floor 326--12th Street
New Westminster, B.C.
V3M 4H6

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