SHOREWORKER BENEFIT FUND:

WEEKLY INDEMNITY (WAGE LOSS)

GENERAL INFORMATION:

Eligibility: worked a total of 120 hours in the plant

Payable for loss of earnings due to

a) illness,

b) injury not covered by EI, WCB or ICBC

c) maternity- 27th week of pregnancy until 15 weeks after the date of birth.

Benefits:

Supplement ....**70%** of lost straight time earnings
Maximum ....**$500** per week

15 weeks per claim for illness or injury or maternity, depending on your "WI Bank".
Waiting period of three days.

Supplemental Unemployment Benefit (SUB)
Payable as a top up of EI benefits for lost earnings due to illness, injury or maternity.

WCB or ICBC reimbursement – you could be eligible for Weekly Indemnity (WI) Benefits as a "top-up" to the level you would have received on regular WI. You must contact the Union office or the SWBF office to receive the proper re-imbursement forms.

Supplement ....**70%** of lost straight time earnings less EI, WCB or ICBC benefits.
Maximum ....**15** weeks

TO FILL OUT FORM:

1. **Member fills out top of page 1 and signs it and signs bottom of page 2**
2. **Doctor fills out page 2**
3. **Company fills out bottom of page 1. Company will send the form to the Benefit Fund.**

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 Floor, 326–12th Street, New Westminster, B. C. V3M 4H6 Tel: 604-519-3644 Fax: 604-524-6944

WEEKLY INDEMNITY CLAIM

INSTRUCTIONS TO CLAIMANT

Please fill out and sign this portion of the claim form and sign the patient authorization on the reverse side. Your doctor and your employer must also complete the form. Mail the completed form to the Shoreworkers' Benefit Fund at the address listed above.

NAME ______________________ PHONE ____________

ADDRESS ______________________ POSTAL CODE ____________

M ____ D ____ Y ____ DATE OF BIRTH | SOCIAL INSURANCE NUMBER | ☐ MALE | ☐ FEMALE

DATE YOU LAST WORKED ____________ DATE OF DISABILITY ____________

GIVE CAUSE OF DISABILITY (if due to an accident, please provide details): ______________________

____

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 FROM:

EI ☐ WCB ☐ ____________ CLAIM NUMBER ICBC ☐ ____________ CLAIM NUMBER

IF HOSPITALIZED, PLEASE INDICATE DATES OF CONFINEMENT: ____________ FROM ____________ TO

DATED ____________ SIGNED ____________

EMPLOYER'S STATEMENT

NAME OF CLAIMANT ____________ PAYROLL # ____________ AGE ____

JOB CLASSIFICATION/S ____________ WAGE RATE ____________

HAS THE CLAIMANT ACCUMULATED 120 HOURS OF WORK? ____________ 400 HOURS OF WORK? ____________

DATE OF HIRE: M ____ D ____ 20 ____ DATE CLAIMANT LAST WORKED ____________

DATE RETURNED TO WORK: M ____ D ____ 20 ____ FIRST DAY WORK WAS MISSED AFTER DATE LAST WORKED ____________

IF CLAIMANT IS LAID OFF, APPROXIMATE RECALL DATE: ____________

CLAIM IS DUE TO: ☐ INJURY ☐ SICKNESS ☐ MATERNITY

HAS RECORD OF EMPLOYMENT BEEN ISSUED IN THE PAST 52 WEEKS? ____________

IS THERE ANY POSSIBILITY OF WCB OR ICBC LIABILITY IN THIS CASE? ____________

DO YOU, WITHOUT RESERVATION, RECOMMEND PAYMENT OF THIS CLAIM? ____________

EMPLOYER ____________ SIGNED BY MANAGEMENT ____________ DATE ____________

PLANT ____________ SIGNED BY SHOP STEWARD ____________ DATE ____________

ATTENDING PHYSICIAN'S STATEMENT

Please complete this form and return it to your patient. Any fees for completion of this form are not the responsibility of the Shoreworkers' Benefit Fund.

PATIENT'S NAME ______________________ AGE ________

DID THIS INJURY OF ILLNESS ARISE OUT OF THE PATIENT'S EMPLOYMENT OR MOTOR VEHICLE ACCIDENT? IF YES, PLEASE EXPLAIN: ______________________

____

IF REFERRED TO YOU, PLEASE GIVE NAME OF REFERRING PHYSICIAN ______________________

IS THIS CLAIM A RESULT OF PREGNANCY? ____________ IF YES, WHAT IS ESTIMATED DATE OF DELIVERY? ____________

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY) ______________________

____

IF HOSPITALIZED, GIVE NAME OF HOSPITAL ______________________

INDICATE ANY SURGICAL PROCEDURES ______________________

______________________ DATE: ____________

DATES OF MOST RECENT VISITS REGARDING THIS DISABILITY

PLACE	MONTH	YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AT OFFICE																																	
AT HOSPITAL																																	

THIS PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM: ____________ TO ____________ (incl.)

IF STILL DISABLED, PLEASE GIVE **APPROXIMATE** DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: ______________________

IS THE PATIENT SCHEDULED FOR RE-ASSESSMENT? ____________ IF YES, DATE ____________

REMARKS THAT MAY BE HELPFUL ______________________

____

____

NAME OF PHYSICIAN ______________________ PHONE ____________

ADDRESS ______________________

DATED ____________ SIGNED ______________________

AUTHORIZATION OF PATIENT

I hereby authorize the release to the Shoreworkers' Benefit Fund of any information requested in respect of this claim.

DATED ____________ SIGNATURE OF PATIENT ______________________