UNITED FISHERMEN'S BENEFIT FUND

TOTAL DISABILITY BENEFIT

General Information: (for complete information contact the UFBF)

Payable to members under 50 years old totally disabled from work. **$5,000**

Type of Benefit

In the event of total and complete disability as a result of sickness or accident, the Fund shall provide a benefit to a qualified member who has not reached the age of 50 years at the time of disability and is permanently and totally disabled and prevented from engaging in any gainful employment.

For a total disability which may not be permanent, the benefit shall be payable after two years of disability, provided it is likely that the claimant will be prevented by disability from being able to resume any gainful employment for an indefinite period.

For a total disability that is not the result of an industrial accident in the fishing industry, the benefit shall be payable if it is established that the claimant has been a member of the Fund and eligible for benefits for five years prior to the date the member was disabled.

Totally Disabled Members Medical Coverage

The Fund shall extend the benefit coverage of extended Health, Dental and Travel Assistance to a qualified member in the event of total and complete disability because of sickness or accident

The above is only a general overview of the Totally Disability Benefits available. These are complex benefits so please contact the United Fishermen's Benefit Fund for details.

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

TOTAL DISABILITY CLAIM

CLAIMANT'S STATEMENT

NAME _____ PHONE _____

ADDRESS _____

DATE OF BIRTH _____ SOCIAL INSURANCE NO._____

MEMBER OF: UFAWU-UNIFOR ❑ NBBC ❑ CANOE PASS CO-OP ❑

FISHING YOU HAVE DONE IN THE PAST FIVE YEARS:

YEARS	TYPE OF FISHING	NAME OF BOAT	COMPANY YOU DELIVERED THE MAJORITY OF YOUR CATCH TO

WHAT DATE DID YOU LAST WORK? _____

WHEN DID YOU BECOME TOTALLY DISABLED? _____

WHAT IS THE NATURE OF YOUR DISABILITY? _____

_____

HOW LONG DO YOU EXPECT TO BE TOTALLY DISABLED AND UNABLE TO WORK? _____

_____

DO YOU BELIEVE THAT YOU ARE PERMANENTLY DISABLED FROM WORKING (PLEASE EXPLAIN) _____

_____

DO YOU INTEND TO RETRAIN OR APPLY FOR OTHER WORK? _____

PLEASE LIST ANY OTHER PENSION OR DISABILITY BENEFITS THAT YOU HAVE BEEN OR MAY BECOME ELIGIBLE FOR: _____

PLEASE LIST ALL PHYSICIANS AND SURGEONS WHO HAVE BEEN CONSULTED DURING YOUR PRESENT DISABILITY:

DR.'S NAME	ADDRESS	PHONE

DECLARATION OF CLAIMANT

I HEREBY MAKE CLAIM TO THE BOARD OF TRUSTEES OF THE UNITED FISHERMEN'S BENEFIT FUND IN ACCORDANCE WITH THE RULES OF THE FUND AND CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE THAT THE DECISION OF THE TRUSTEES UPON THIS CLAIM WILL BE ACCEPTED BY ME AS FINAL. I UNDERSTAND THAT PAYMENT OF THE CLAIM MAY TAKE UP TO TWO YEARS.

DATED: _____ SIGNED: _____

PLEASE SEND A COPY OF YOUR BIRTH CERTIFICATE OR OTHER PROOF OF AGE WITH THIS CLAIM.

DECLARATION OF CLAIMANT

PLEASE COMPLETE THIS STATEMENT AND RETURN THE FORM TO YOUR PATIENT. ANY FEES FOR COMPLETION OF THIS FORM ARE NOT THE RESPONSIBILITY OF THE UNITED FISHERMEN'S BENEFIT FUND.

PATIENT'S NAME _____ AGE _____

1. WHEN DID THE PRESENT ILLNESS BEGIN OR INJURY OCCUR? _____
2. WHEN WAS THE PATIENT DISABLED FROM REGULAR WORK? _____
3. DIAGNOSIS (PLEASE DESCRIBE ANY PERMANENT DISABILITY OR CONDITION) _____

_____

_____

_____

_____

4. DATE OF FIRST TREATMENT _____

   DATE OF LAST EXAMINATION _____
5. FREQUENCY OF VISITS _____
6. PLEASE INDICATE THE PATIENT'S PROGRESS:

   RECOVERED ❑ IMPROVED ❑ UNIMPROVED ❑ RETROGRESSED ❑
7. WHEN DO YOU THINK THE PATIENT WILL BE FIT TO RETURN TO REGULAR WORK?

   APPROXIMATE DATE: _____ 20 _____ INDEFINITE ❑ NEVER ❑
8. WILL THE PATIENT BE ABLE TO DO OTHER WORK? (IF "**YES**", PLEASE EXPLAIN) _____

_____

_____

_____

9. IS THE PATIENT, TOTALLY AND PERMANENTLY DISABLED AND THEREBY PREVENTED FROM ENGAGING IN ANY GAINFUL EMPLOYMENT? _____

_____

_____

_____

NAME OF PHYSICIAN _____ PHONE _____

ADDRESS: _____

_____

DATED _____ SIGNED _____