

BENEVOLENT FUND APPLICATION FOR BENEFITS

16214 - 118 Avenue - Edmonton, Alberta T5V 1M6

Phone: (780) 452-7080 Fax: (780) 452-1291

www.local488.ca

PLEASE PRINT CLEARLY - INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

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NAME					SIN				
ADDRESS									
CITY				PROVINCE			POSTAL CODE		
HOME NUMBER ()				CELL NUMBER ()				
NATURE OF DISABILITY									
DATE OF DISABILITY MONTH	DAY	YEAR	DATE Y	OU EXPECT TO RETURN T	_	MONTH	DAY	YEAR	
ARE YOU RECEIVING WCB BENEFI		TEAR	1	YES	NO _]	D/II		
ARE YOU IN A RETRAINING PROGRAM?				YES	NO _]			
ARE YOU WAITING FOR SURGERY?				YES	NO _]			
ARE YOU APPLYING FOR CANADA DISABILITY BENEFITS?				YES	NO _]			
ARE YOU IN THE HOSPITAL NOW?				YES	NO _]			
The funding of the Local Union #488 B in order to allow for the Funds operation									
I hereby authorize the Members of t my claim under this fund with and ir									
Member's Signature					Da	ite			

ALL APPLICATIONS FOR DISABILITY BENEFITS MUST BE ACCOMPANIED WITH THE APPROPRIATE DOCUMENTATION!

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1.	PATIENT'S NAME								
2.	IS CONDITION DUE TO INJURY OR SICKNESS ARISING:	(A) OUT OF PATIENT'S EMPLOYMENT	YES NO [□ UNKNOWN □					
		(B) FROM A MOTOR VEHICLE ACCIDENT	YES NO [
3.	DIAGNOSIS OR PRESENT CONDITION								
	(A) PRIMARY								
	(B) SECONDARY (IF APPLICABLE) OR ADDITIONAL CONE	OITIONS WHICH MIGHT AFFECT DURATION (OF DISABILITY						
4.	TO THE BEST OF MY KNOWLEDGE								
	(A) SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPE	NED YEAR MONTH DAY							
	(B) PATIENT HAS HAD SAME OR SIMILAR CONDITION YES □ NO □								
	(C) IF "YES", STATE WHEN AND DESCRIBE								
5.	DATE OF HOSPITAL IN-PATIENT ADMISSION	DATE OF HOSPITAL OUT-	PATIENT ADMISSI						
	DATE OF HOSPITAL DISCHARGE	MONTH DAY		YEAR MONTH DAY					
	YEAR	MONTH DAY		YEAR MONTH DAY					
6.	IF SURGERY WAS PERFORMED, ENTER DATE YEAR YEAR	MONTH DAY WAS GENERAL ANAESTH	ETIC ADMINISTER	RED?					
	DESCRIPTION								
	US DEFENDED TO VOLUME NAME OF DEFENDING DIVIN	OLOLAN							
7.	IF REFERRED TO YOU, GIVE NAME OF REFERRING PHYS			1 1					
8.	(A) DATE OF FIRST VISIT FOR PRESENT PERIOD OF DISABILITY YEAR	MONTH DAY	TEST ATTENDANG	CE YEAR MONTH DAY					
	(C) WERE YOU ACTIVELY SUPERVISING THIS PATIENT IF "NO", PLEASE EXPLAIN	'S CARE DURING THE FULL REPORT PERIO	D? YES □	NO 🗆					
	IF "YES", STATE FREQUENCY OF VISITS WEEK NATURE OF TREATMENT	KLY MONTHLY OTHER (5	SPECIFY)						
9.	IF CONDITION IS DUE TO PREGNANCY, WHAT IS (OR WA	S) THE EXPECTED DATE OF CONFINEMENT	YEAR MON	NTH DAY					
10.	HOW DOES PRESENT CONDITION AFFECT PATIENT'S AI	BILITY TO WORK?							
11.	(A) TO THE BEST OF MY KNOWLEDGE, THE PATIENT HA	S BEEN TOTALLY DISABLED (UNABLE TO WO	ORK)						
	FROM	INCLUSIVE INCLUSIVE							
	(B) IF STILL DISABLED, GIVE APPROXIMATE DATE WHEN		WORK	MONTH DAY					
	OR, IF INDEFINITE, THE ESTIMATED NUMBER OF ADDITI	ONAL WEEKS BEFORE SUCH RETURN							
12.	HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISAB	BLED? (ABLE TO WORK PART-TIME AT OWN	OCCUPATION)						
	FROM YEAR MONTH DAY TO YEAR MO	NTH DAY INCLUSIVE							
PH	YSICIAN'S NAME (PRINT)								
AD	DRESS								
	EPHONE NUMBER								
	NED THIS DAY OF 2								
I HEREBY AUTHORIZE THE RELEASE TO THE PLAN ADMINISTRATOR ANY INFORMATION REQUESTED IN RESPECT OF THIS CLAIM.									
SIC	NED THIS DAY OF 2	20 SIGNATURE OF PATIENT							
	THIS PATIENT IS RESPONSIBLE FOR SEC	HIDING THIS EODM AND EOD OUA	DOES MADE F	OD ITS COMDI ETION					

Return the completed form to:
EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
16214 - 118 AVENUE, EDMONTON, ALBERTA T5V 1M6
TELEPHONE: 780-452-1331

