Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca

# Disability Notice

SECTION 1 – TO BE COMPLETED BY PLAN MEMBER

**Plan Policy Number:** 6012

**Plan Member** – Last Name, First Name and Initial EBFA Stakeholder Number:

Address: City/Province/Postal Code: Telephone Number:

Birthdate: Height: Weight: Gender: ☐ Male ☐ Female

1. Reason for leaving work (check one):

☐ Disability ☐ Leave of Absence ☐ Strike ☐ Temporary Layoff ☐ Dismissed

☐ Regular Layoff ☐ Quit ☐ Retired

2. Last Day Worked _____ (dd/mm/yy) Number of hours worked that day _____

3. If Insurance coverage has terminated, please give date _____ (dd/mm/yy)

4. Is condition due to work related accident or illness? ☐ No ☐ Yes

Has a claim been filed with WCB? ☐ No ☐ Yes If Yes, claim number _____

Are you presently receiving Workers' Compensation Benefits? ☐ No ☐ Yes

If work related but no claim filed, please provide reason _____

_____

_____

5. Has a claim been filed with Employment Insurance for regular EI benefits ? ☐ No ☐ Yes

Are you presently receiving EI regular benefits? ☐ No ☐ Yes

Has a claim been filed with EI for Sickness and Accident benefits ? ☐ No ☐ Yes

Are you presently receiving EI Sickness and Accident benefits? ☐ No ☐ Yes

If yes, please provide a copy of your first and last EI Sickness and Accident paystub.

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



6. Plan Member's current basic weekly earnings $_____ ☐ Tax Exempt ☐ Basic ☐ Other Code___

7. Hourly rate of pay $_____ Regular hours per week _____ Rate of benefit $_____

8. Please indicate normal working days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

If non standard cycles, please describe _____

_____

9. Has payment been made (or will be made) to you for any vacation days or holidays during the period being claimed? ☐ No ☐ Yes If yes, provide dates _____

_____

10. Do you expect to return to work? ☐ No ☐ Yes If yes, give approximate date _____
( dd/mm/yy)

11. Is modified or part time work available? ☐ No ☐ Yes

12. Prior to the last day worked, were you currently working (please check one of the following):

☐ Full Time ☐ Part Time ☐ Full time on modified duties ☐ Part time on modified duties

13. If modified, from what date _____ Was it a result of work related absence? ☐ No ☐ Yes
( dd/mm/yy)

14. Please provide a brief job description _____

_____

_____

15. If disability benefits are payable from any other source, please identify and state amount.

_____

_____

16. Please furnish any other information you believe is pertinent to this claim.

_____

_____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



17. What are the duties of your usual job? _____

_____Job Title_____

18. On what date were you first unable to work? _____ at ☐ A.M. ☐ P.M.
(dd/mm/yy)

19. On what date do you expect to return to work? _____
(dd/mm/yy)

20. Have you discussed modified duties or a part time return to work with your physician? ☐ No ☐ Yes
What was his/her response? _____

21. Is your disability due to an accident? ☐ No ☐ Yes If yes, please answer the following questions:

When did it happen? _____ at _____ ☐ A.M. ☐ P.M.

Where did it happen? ☐ at home ☐ at work ☐ elsewhere (name place) _____

How did it happen? _____

_____

Was the accident reported to the police? ☐ No ☐ Yes If yes please provide name of police officer and address of detachment and provide copy of police report. _____
_____

Are you taking action against a third party? ☐ No ☐ Yes If yes, provide your lawyer's name and address.
_____

List names and addresses of physicians (other than the physician who completed the claim form) who have treated you in connection with this condition
_____

_____

22. Have you been hospitalized for this condition? ☐ No ☐ Yes
If yes, date hospitalized _____ to _____
(dd/mm/yy) (dd/mm/yy)

23. Have you (or will you) applied for any other disability benefits from any other source as a result of this condition? ☐ No ☐ Yes If yes, please provide the name of the source _____
_____

24. Do you have coverage through your Provincial Plan? ☐ No ☐ Yes Prov. Plan No: _____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



## Section II – Declaration and Authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize The Manufacturers Life Insurance Company (Manulife Financial) and the Electrical Industry Insurance Benefit Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Manulife Financial and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where Manulife Financial and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with Manulife Financial or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize Manulife Financial or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I understand that any Personal Information that I provide, or which Manulife Financial or the Fund has collected, will be kept by Manulife Financial or the Fund in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife Financial or the Fund and other persons (corporate or individual), firms or agencies engaged by Manulife Financial or the Fund, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law. I understand that where Manulife Financial or the Fund has obtained sensitive medical information from someone other than my physician, Manulife Financial or the Fund will only release such information through my physician.

I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for Manulife Financial or the Fund. A copy of this authorization shall be valid as the original.

_____ _____

Signature of Plan Member (in full) Date (dd/mm/yy)

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



Section III – TO BE COMPLETED BY ATTENDING PHYSICIAN

Please provide all information and documentation as requested on this form so that we can better understand the extent of your patient's condition and the resulting impairments. The information provided will form the basis upon which entitlement to benefits will be assessed.

All information on this form should be clearly printed.

Physician- Last Name, First Name and Initial Specialty:

Physician – Address: No. Street: City: Province: Postal Code:

Telephone Number (including area code): Facsimile Number: Physician's Email: Address

Plan Policy Number: 6012

Patient's - Last Name, First Name and Initial Telephone Number (including area code):

Patient's – Address: No. Street: City: Province: Postal Code:

Patient's Date of Birth: Gender: ☐ Male ☐ Female

1. Diagnosis of present condition (please print):

a) Primary _____

b) DSM IV terminology codes:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

c) Secondary _____

d) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

e) Please enclose copies of the following documents in support of the stated diagnosis:

☐ consultation notes ☐ test/investigation reports ☐ assessment reports

☐ psychological testing reports ☐ hospital admission history ☐ clinical notes

☐ operative reports ☐ other _____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



2. Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes

3. To the best of your knowledge, indicate when symptom(s) first appeared (dd/mm/yy) _____

(a) Patient has been unable to perform his/her duties as an electrician since (dd/mm/yy) _____

4. Has the patient had same or similar condition? ☐ No ☐ Yes
If yes, please state when and describe.

_____

_____

5. Please state all current symptoms on which your diagnosis is based

_____

_____

6. Current Impairments

(i) Physical Impairment - please check:

☐ Class 1 (no impairment – capable of strenuous physical activity)

☐ Class 2 (slight limitation – capable of moderate activity)

☐ Class 3 (moderate limitation – capable of light activity)

☐ Class 4 (marked limitation – capable of minimal activity)

☐ Class 5 (severe limitation – incapable of minimal activity)

(ii) Is your patient:

☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

(iii) Is your patient capable of:

☐ Lifting _____ kgs/lbs ☐ Sitting ☐ Walking ☐ Squatting ☐ Standing

☐ Bending ☐ Climbing

(iv) Does your patient require assistive devices? If yes, please specify_____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



(v) Psychiatric Impairments – please check:

☐ Class 1 (able to function under stress and engage in interpersonal relationships – no limitations)

☐ Class 2 (able to function in most stress situations and engage in most interpersonal relationships – slight limitation)

☐ Class 3 (able to engage in only limited stress situations and limited interpersonal relationships – moderate limitation)

☐ Class 4 (unable to engage in stress situations or engage in interpersonal relationships – marked limitation)

☐ Class 5 (patient has significant loss of psychological and social abilities – severe limitation)

(vi) How does your patient's psychiatric disorder affect his/her ability to work? Please provide specific restrictions and limitations.

_____

_____

7. Please provide specific restrictions and limitations.

_____

8. Other factors influencing condition (for example – work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional licence etc.) _____

9. Is there an alcohol or substance abuse problem? ☐ No ☐ Yes If yes, please specify treatment center and program details.

_____

_____

10. Current medications. Please specify names of drugs, dosages, start dates and duration.

_____

_____

_____

Response to treatment:

_____

_____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



11. Other treatment – for example, physiotherapy, counseling, day treatment programs. Please specify type, frequency and full name of facility.

_____

_____

Response to treatment:

_____

_____

12. Dates Hospitalized (recent) Admission Date _____ Discharge Date_____
(dd/mm/yy) (dd/mm/yy)
Institution: _____ Reason: _____

13. Compliance: Is your patient following the recommended treatment program? ☐ No ☐ Yes If no, please explain:

_____

Please state frequency of visits: ☐ weekly ☐ monthly ☐ other, please specify _____

Date of first visit and all subsequent visits during present period of absence from work:

_____

Please provide details of any proposed treatment plan including any recommended surgery.

_____

Have you referred your patient to any other physician? ☐ No ☐ Yes If yes, please provide the full name and specialty _____

14. What do you understand your patient's occupation to be?_____

Are you familiar with the requirements of your patient's occupation? ☐ No ☐ Yes If yes, please comment

_____

Has your patient expressed a desire to return to work? ☐ No ☐ Yes If yes, please comment

_____

What are your patient's specific work restrictions / limitations? _____

_____

Please confirm the date your patient was/will be capable of returning to the workforce (dd/mm/yy)

☐ To Own Occupation _____ ☐ To any other occupation _____

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca



15. Is your patient competent to endorse cheques and direct the use of the proceeds? □ No □ Yes
If no, from what date? _____(dd/mm/yy)

16. Has your patient's professional licence, certification, driver's or other licence been □ Restricted □ suspended □ revoked. If yes, date (dd/mm/yy) _____ Type of licence _____ Class _____

17. Additional Remarks:

18. Have you provided medical information on your patient's behalf for other benefits? If yes, please provide the full name of the company

_____

_____

Section 3 - PHYSICIAN DECLARATION

I declare that the information on this statement is true to the best of my knowledge.

_____ _____

Physician's Signature (in full) Date: (dd/mm/yy)