British Columbia Life & Casualty Company

Waiver of Premium
Claim Checklist

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Help us to process your claim quickly and accurately. Ensure that the following forms are completed and that the originals of these forms are submitted:

- ☐ Waiver of Premium Claim Form
- ☐ Initial Attending Physician's Statement
- ☐ Claimant Questionnaire

Your claim for this benefit must be submitted to BC Life by your policy claiming deadline. If you have any questions about your claim or about these forms, please contact our BC Life Claims Department at 604 419-8040.

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1

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92-60-115 05/04 CUPE 1816

British Columbia Life & Casualty Company

Waiver of Premium
Claim Form

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Employer's Statement

Name of group policyholder ______________________ Policy number ____________

Name of employee ______________________ Social insurance number ____________

Date employed [Mo | Day | Yr] Occupation ______________________

Date last worked [Mo | Day | Yr] Date returned to work or expected to return to work [Mo | Day | Yr]

Effective date of employee's insurance [Mo | Day | Yr] Date premiums paid to [Mo | Day | Yr]

Basic earnings on last day worked $ ________ per ________ Amount of insurance on last day worked $ ____________

Please provide any other information that will help BC Life assess this claim ______________________

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Completed by (please print) ______________ Phone number ______________ Date [Mo | Day | Yr]

Signature of authorized official ______________________ Title ______________

Employee's Statement (must be completed by employee)

Name ______________________ Date of birth [Mo | Day | Yr]

Address ______________________ Box no. if applicable ____________

City ______________ Province ______ Postal Code ________ Phone number ____________

Are you now medically unable to work? ❑ Yes ❑ No If yes, provide date last able to work [Mo | Day | Yr]

Describe the illness or injury that prevents you from working ______________________

____

If condition was caused by an accident, state how, when, where the accident occurred ______________________

____

List all physicians, surgeons and practitioners who have treated you for this condition

Name	Address	Dates of attendance	Disease or condition
		Mo / Day / Yr	
		Mo / Day / Yr	
		Mo / Day / Yr	

Have you been hospitalized for this condition? ❑ Yes ❑ No If yes, provide hospital information below:

Name of hospital	Date admitted	Date discharged
	Mo / Day / Yr	Mo / Day / Yr

What activities can you perform? ______________________

When do you expect to return to work? Please provide approximate date [Mo | Day | Yr]

I, the undersigned, hereby make claim for the above mentioned benefit. I authorize the release of all reports and medical information which may be needed to establish the validity of this claim to British Columbia Life & Casualty Company (BC Life). I agree that a photocopy of this authorization shall be as valid as the original. I certify that the above answers are true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of employee ______________________ Date [Mo | Day | Yr]

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Initial Attending Physician's Statement

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Please assist your patient by providing all details relevant to his/her condition. Cross out those questions that are not applicable.

1. Name of patient: ____________________ Date of birth ___ ___ ___ (Mo Day Yr)

2. Patient's: Height __________ Weight __________ ❑ Male ❑ Female

3. Diagnosis: ____________________

4. Additional conditions or complications: ____________________

5. Does your patient require treatment for substance abuse? ❑ Yes ❑ No If yes, is this treatment under way, what type of treatment and when did it start?

6. DSM IV (if applicable): ____________________ GAF score: __________

7. Objective findings **(please include copies of test results: current X-rays, diagnostic tests, E.K.G.'s, blood pressure readings, etc.):**

8. Subjective complaints (including severity and frequency): ____________________

9. Date symptoms began: ___ ___ ___ (Mo Day Yr) Date your patient stopped work due to these symptoms: ___ ___ ___ (Mo Day Yr)

10. Has your patient ever had the same or similar condition? ❑ Yes ❑ No If yes, when, and provide details: ____________________

11. Is this condition caused in any way by the patient's employment? ❑ Yes ❑ No If yes, have you submitted a WCB claim form? ❑ Yes ❑ No

12. Date of first visit: ___ ___ ___ (Mo Day Yr) Date of most recent visit: ___ ___ ___ (Mo Day Yr)

13. Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (specify): ____________________

14. Medications: provide type, start date, dosage and frequency, response and adjustment date if applicable ____________________

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15. Please provide details of other treatment (surgery, physiotherapy, psychotherapy, etc.) including dates, recommended frequency, etc. ________

16. Is your patient following the recommended treatment? ❑ Yes ❑ No If yes, what has been the response? If no, explain ____________

17. Names, addresses and specialty of other physicians or treatment providers referred to: **(please include copies of any consultation and follow up reports)**

Name	**Address**	**Specialty**

18. Has your patient been hospitalized? ❑ Yes ❑ No If yes, provide dates Date admitted ___ Mo ___ Day ___ Yr Date discharged ___ Mo ___ Day ___ Yr

Name and address of hospital: ____________________

19. What are your patient's mental and physical limitations and how do they affect the activities of daily living? ____________________

20. Has your patient: ❑ recovered ❑ improved ❑ not improved ❑ retrogressed

21. If appropriate treatment is followed, do you expect your patient to return to pre-illness/accident functioning? ❑ Yes ❑ No

If yes, when? ____________________

If no, please explain ____________________

22. If there are other factors affecting recovery, please explain ____________________

23. Do you believe your patient is competent to endorse cheques and direct the use of the proceeds? ❑ Yes ❑ No

24. Please provide any additional information you believe we should be aware of concerning your patient's condition:

These statements are true and complete to the best of my knowledge and belief.

Name and specialty (please print) ____________________

Address (please print) ____________________ Phone Number ____________________

Signature ____________________ MD Date ___ Mo ___ Day ___ Yr

The claimant is responsible for the cost of completing this form.

BC Life British Columbia Life & Casualty Company

Claimant Questionnaire

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Name of claimant ______________________________ Social insurance number ______________

Occupational Information

Your job title ______________________________ Number of years performing this job __________

Describe the essential duties of your job. ______________________________

____

____

____

Is there any specialized equipment you are required to use on a daily basis? ❑ Yes ❑ No If yes, please describe: ______________

____

____

____

Please indicate the approximate number of hours you are involved in the following activities during your normal work day:

Walking ____________ Standing ____________ Sitting ____________ Bending ____________

Only complete this section if your job involves *lifting, carrying* and *reaching*. Please check in the applicable spaces below, those physical activities required in your job.

Physical activities required			**Total hours performed daily**				
			Less than 1	1-2	3-4	5-6	7-8
LIFTING	☐	under 10 pounds	☐	☐	☐	☐	☐
	☐	11 - 20 pounds	☐	☐	☐	☐	☐
	☐	21 - 50 pounds	☐	☐	☐	☐	☐
	☐	over 50 pounds	☐	☐	☐	☐	☐
CARRYING	☐	under 10 pounds	☐	☐	☐	☐	☐
	☐	11 - 20 pounds	☐	☐	☐	☐	☐
	☐	21 - 50 pounds	☐	☐	☐	☐	☐
	☐	over 50 pounds	☐	☐	☐	☐	☐
REACHING	☐	Reaching above shoulder height	☐	☐	☐	☐	☐
	☐	Reaching at shoulder height	☐	☐	☐	☐	☐
	☐	Reaching below shoulder height	☐	☐	☐	☐	☐

Do you expect to be able to return to your job in the near future? ❑ Yes ❑ No If yes, on a part-time or full-time basis? ____________

Do you believe your duties can or will need to be modified in order to allow you to return? ❑ Yes ❑ No Please explain: ____________

____

____

Have you discussed a return to work with your employer, either to your present job, or to some other position with your company? ❑ Yes ❑ No

If yes, provide details of discussion. ______________________________

____

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Medical Information

Please describe any limitations and restrictions you have as a result of your medical condition(s). ____________________

____

____

Describe in detail the way in which your symptoms prevent you from performing any or all of the essential duties of your job. ____________________

____

____

Education and Employment Background

Highest grade achieved (please circle) 1 2 3 4 5 6 7 8 9 10 11 12 13

Technical or trade school attended ____________________ Diploma obtained ____________________

Apprenticeships ____________________

College or University:

(a) Name of college or university ____________________

(b) Years completed ____________________ (c) Degree obtained ____________________ (d) Major ____________________

Other (vocational courses, programs, training, certificates, etc. and year completed or obtained) ____________________

____

Language(s) spoken fluently ____________________

Please complete the following, providing details on the jobs you have held (last job first). If insufficient space, please attach a separate sheet.

Employer	Job title	Dates of employment	Essential job duties performed

Skills and Interests

What job skills have you acquired in your current and previous jobs? ____________________

____

Please describe any community projects or volunteer work that you are or have been involved with. ____________________

____

What are your hobbies or interests ? ____________________

____

Are there any jobs that you are interested in, such as ones based upon your hobbies/interests, previous work experience, and/or education?

____

Do you currently have: a) a valid driver's license? ❑ Yes ❑ No What class? ____________________

c) any driving restrictions as a result of your condition? ❑ Yes ❑ No Explain ____________________

b) a car ❑ Yes ❑ No

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Signature of claimant ____________________ Date ____ Mo ____ Day ____ Yr