The City of Hamilton

CUPE 5167 Claim form-Income Protection Benefits (Short Term Disability)

Forward Completed Form to:

Mailing Address:

Return to Work Services
Human Resources
71 Main Street West
HAMILTON, ON L8P 4Y5

Physical Address

Return to Work Services
Human Resources
Standard Life Building
120 King Street West, Suite 970, HAMILTON, ON L8P 4V2 **Fax: 905-546-4174**

Instructions:

1. Please Print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.
5. Following the claims decision, this document will be forwarded to the appropriate Return to WorkServices Staff and will become part of the Employee's confidential health record separate from the Employee's personnel file.
6. Claims Forms are required to be submitted as per the Collective Agreement or otherwise as directed by the Employer.
7. Both Part 1 and 2 must be completed **in full** before S.T.D. payments can be authorized
8. Employee may be required to provide additional medical information where reasonably necessary to determine eligibility for disability or to evaluate work accommodation alternatives.

Personal information contained on this form is collected pursuant to section 8 of the Municipal Act,, 2001, and will be used a) by Return to Work Services, independent medical,or Long Term Disability Carrier to determine eligibility for disability benefits and b) Return to Work Services to evaluate work accommodation alternatives. Questions about this collection should be directed to the Director of Employee and Labour Relations

PART 1 EMPLOYEE STATEMENT - TO BE COMPLETED PRIOR TO SUBMITTING TO PHYSICIAN (please print)

1. Name:	Department:	Employee No:
2. Start of Present Absence: (day/month/year)	Is This Absence a Result of a Workplace Accident/Incident? [ ] Yes [ ] No	
3. Occupation/Title:	Physical Effort Required: [ ] light [ ] moderate [ ] heavy	

Employee Authorization: The above information is accurate to the best of my knowledge, and I hereby authorize my physician to release the following and subsequent information toReturn to Work Services Human Resources 120 King StreetWest, Suite 970 HAMILTON, ON L8P 4V2 Fax number 905-546-4174 in respect to my claim for short term disability benefits.
I further agree to the recovery of sick benefits received in the amount of 20% per paycheque if it is found that the independent medical information provided does not support an absence from work.

Employee Signature Date: (day/month/year)

PART 2 ATTENDING PHYSICIAN'S STATEMENT (incomplete information will result in the Employee being non-paid) (please print)

1. To the best of your knowledge indicate when symptoms first appeared or accident happened (day/month/year)

2. Is condition due to injury or sickness arising out of patient'semployment: [ ] Yes [ ] No [ ] Unknown

3. Date of hospital in-patient admission (day/month/year)	Date of discharge (day/month/year)

4. Nature of treatment
Medication ☐ Counselling ☐
Surgery ☐ Physical Rehabilitation ☐
If none, please explain:

5. a) If patient was referred to you, give name of referringphysician.	b) If you have referred patient to a specialist, give name(s) of physicians
6. a) Date of first visit during present period of absence from work (day/month/year)	b) Date of latest attendance (day/month/year)

c) Were you actively supervising this patient's care during the full period
[ ] No, comment in remarks
[ ] Yes, state frequency of visits [ ] Weekly [ ] Monthly [ ] Other (specify)

7. a) To the best of my knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
From (day/month/year) To (day/month/year) inclusive

b) If still unable to work, give approx. date patient should be able to return **OR** the estimated number of weeks before possible return

8. The Employer has a proactive work accommodation policy. In light of your response to Part 2 No. 7, above, is this Employee capable of performing their regular or modified duties at the present time?

[ ] No, (please provide explanation, e.g. nature of restrictions, limitations)

[ ] Modified Duties (please provide explanation, e.g. nature of restrictions, limitations)

[ ] Regular Duties

9. Restrictions and Limitations: Please provide details of the employees restrictions and limitations as it pertains to their ability to work

10. Remarks - Please provide comments and further details which you feel would be helpful

Name of Attending Physician (please print)	Speciality	Telephone No. Fax No.

Address (number, street, city, province, postal code)

Signature	Date (day/month/year)