



# Local 183 Members' Benefit Fund



Policy No. SG10395001

Permanent and Total Disability Accident

# Local 183 Members' Benefit Fund

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## *Claim Application Form*

### **Permanent and Total Disability Accident**

#### **SUBMISSION INSTRUCTIONS:**

- Member to complete and sign Claimant's Statement and Authorization Form.
- Attending Physician to complete and sign the Physician's Statement.
- Policy No. SG10395001. Please keep a copy of completed application package for your records to substantiate your claim.
- Send completed application and supporting documents via fax, e-mail or mail to:

#### **Local 183 Trust Administration**

1263 Wilson Avenue, Suite 205  
Toronto, ON M3M 3G2

Tel: 416-240-7487

Fax: 416-240-7488

Toll Free Line: 1-888-790-3534

E-mail: [info@183membersbenefits.ca](mailto:info@183membersbenefits.ca)



**PERMANENT AND TOTAL DISABILITY  
CLAIMANT'S STATEMENT**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
Toronto, Ontario M5L 1E2  
O +1.416.594.2627 or +1.877.772.7797  
[claims.A\\_H@chubb.com](mailto:claims.A_H@chubb.com)

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

**TO BE COMPLETED BY THE CLAIMANT.**

<b>Policy Number:</b>		<b>Claim No.:</b>	
<b>Name:</b>			
<b>Address:</b>			
<b>City:</b>		<b>Province:</b>	<b>Postal Code:</b>
<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Date of Birth:</b>	
<b>Date of Accident:</b>			
<b>Description of Accident (State where and how):</b>			
<b>Date First Unable to Work:</b>		<b>Date First Medical Attendance:</b>	
<b>Date Returned to Work:</b>		<b>Expected Return to work:</b>	
<b>Have you had same or similar condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>Describe:</b>			
<b>Name of Physicians:</b>		<b>From:</b>	<b>To:</b>
<b>Address:</b>			
<b>Name of Physicians:</b>		<b>From:</b>	<b>To:</b>
<b>Address:</b>			
<b>Name of Hospitals:</b>		<b>From:</b>	<b>To:</b>
<b>Address:</b>			
<b>Name of Hospitals:</b>		<b>From:</b>	<b>To:</b>
<b>Address:</b>			
<b>Have you applied for or are you received:</b> <input type="checkbox"/> C.P.P./Q.P.P. <input type="checkbox"/> Employer Disability <input type="checkbox"/> Automobile Ins. <input type="checkbox"/> W.C.B./W.S.I.B. <input type="checkbox"/> Other			
<b>If yes, where applicable, please provide name:</b>			
<b>Insurer:</b>			
<b>Policy Number:</b>		<b>and in any case, the amount of benefit: \$</b>	

**EMPLOYMENT DETAILS**

<b>Name of Employer:</b>		<b>Occupation:</b>	
<b>Date of Hire:</b>		<b>Last Day Worked:</b>	
<b>Hours Worked / Week</b>			

**EDUCATION / VOCATIONAL BACKGROUND**

<b>Level of Education:</b>		<b>Date Completed:</b>	
<b>Other Courses / Training</b>			
<b>Past Types of Employment:</b>			

**IMPORTANT: PLEASE COMPLETE AND SIGN THE ATTACHED AUTHORIZATION FORM.**

**Privacy Notice:** I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit [chubb.com/ca](http://chubb.com/ca) or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.



**AUTHORIZATION TO  
OBTAIN INFORMATION  
(CLAIMANT)**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
Toronto, Ontario M5L 1E2  
O +1.416.594.2627 or +1.877.772.7797  
[claims.A\\_H@chubb.com](mailto:claims.A_H@chubb.com)

**Name of Insured:**

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning myself to give to Chubb Insurance or Chubb Life Insurance all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as a claimant and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this consent shall be as valid as the original.

Name (Please Print) \_\_\_\_\_ Signature \_\_\_\_\_

Dated at \_\_\_\_\_ of \_\_\_\_\_  
City/Town Region/Municipality

In the Province of \_\_\_\_\_ on this \_\_\_\_\_ day

of \_\_\_\_\_  
Month and Year

Signature of Parent/Guardian if Child is a Minor \_\_\_\_\_



**PERMANENT AND TOTAL DISABILITY  
ATTENDING PHYSICIAN'S STATEMENT**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
Toronto, Ontario M5L 1E2  
O +1.416.594.2627 or +1.877.772.7797  
[claims.A\\_H@chubb.com](mailto:claims.A_H@chubb.com)

**PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT**

**THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION**

**AUTHORIZATION OF PATIENT**

<b>Policy Number(s):</b>	<b>Name:</b>	
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>

I hereby authorize the release to Chubb Insurance and/or Chubb Life Insurance Company of Canada of the information requested in this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

<b>Patient's Name:</b>	<b>Date of Birth:</b>
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**HISTORY**

<b>Check One:</b> <input type="checkbox"/> Accident <input type="checkbox"/> Sickness
<b>When did symptoms first appear or accident happen?</b>
<b>Date patient ceased work because of disability:</b>
<b>Has patient ever had same or similar condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>State when &amp; describe:</b>
<b>Is condition due to injury or sickness arising out of employment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Names of any other treating Physicians:</b>
<b>Address:</b>

**DIAGNOSIS (if applicable)**

<b>Primary:</b>
<b>Secondary (if applicable):</b>
<b>Subjective Symptoms:</b>
<b>Objective Findings (x-rays, laboratory, EKG, clinical findings):</b>

**TREATMENT**

<b>Date of First Visit:</b>
<b>Date of Latest Visit:</b>
<b>Frequency:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify):
<b>Date of Hospitalization: Confined From:</b> _____ <b>To:</b> _____

**NATURE OF TREATMENT**


**PHYSICAL IMPAIRMENT**

<b>Degree of Limitation of Functional Capacity:</b>
<input type="checkbox"/> Class 1 – No limitation of functional capacity: capable of heavy physical activity, no restrictions. (0 - 10%)
<input type="checkbox"/> Class 2 – Slight limitation of functional capacity: capable of light manual activity. (15 - 30%)
<input type="checkbox"/> Class 3 – Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity. (35 - 55%)
<input type="checkbox"/> Class 4 – Marked limitation. (60 - 70%)
<input type="checkbox"/> Class 5 – Severe limitation of functional capacity: incapable of minimal (sedentary) activity. (71 -100%)

**MENTAL/NERVOUS IMPAIRMENT (if applicable)**

<input type="checkbox"/> Class 1 – Able to function under stress and engage in interpersonal relations. (No limitations)
<input type="checkbox"/> Class 2 – Able to function in most stress situations and engage in most interpersonal relations. (Slight)
<input type="checkbox"/> Class 3 – Able to engage in only limited stress situations and limited interpersonal relations. (Moderate)
<input type="checkbox"/> Class 4 – Unable to engage in stress situations or engage in interpersonal relations. (Marked)
<input type="checkbox"/> Class 5 – Significant loss of psychological, personal and social adjustment. (Severe)

**PROGRESS**

Is patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital Confined
Limitation which prevents return to own occupation?
Limitation which prevents return of any other occupation?

**PROGNOSIS**

Is patient now totally disabled from Own job? <input type="checkbox"/> Yes <input type="checkbox"/> No      Any other Job: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate when patient will be capable of performing duties of:
Own Job: <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Never <input type="checkbox"/> Other (Specify):
Any Other Job: <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Never <input type="checkbox"/> Other (Specify):
If no, please indicate date patient will be able to perform duties on:

**VISUAL (if applicable)**

What was vision at latest observation?	With glasses:	O.D.	O.S.
	Without glasses:	O.D.	O.S.
Vision can be restored in whole or part by:	O.D. <input type="checkbox"/> Lenses <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Not Restorable		
	O.S. <input type="checkbox"/> Lenses <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Not Restorable		

**REMARKS**


<b>Name of Attending Physician:</b>	<b>Degree:</b>
<b>Phone #: (     )</b>	<b>Fax #: (     )</b>
<b>Address:</b>	
<b>City:</b>	<b>Province:</b> <b>Postal Code:</b>

Signature \_\_\_\_\_ Date \_\_\_\_\_