ACAW TRUST FUNDS

Suite 101, 15315 - 123 Ave NW, Edmonton, AB T5V 1S6
Phone: 780-477-9131
Option #1: Health & Wellness Plan
Option #3: Self Payments, Weekly Disability & Life Insurance

Toll Free: 1-800-588-1037, Option #1 or #3
Fax: 780-477-9134
Email: info@acawtrustfunds.ca
www.acawtrustfunds.ca

ACAW HEALTH & WELLNESS PLAN • **WEEKLY DISABILITY BENEFITS** • *INFORMATION DOCUMENT*

The purpose of this information is to provide you with an understanding of the Weekly Disability Benefit provided by the ACAW Health & Wellness Plan.

Please read the information on these pages carefully and completely before proceeding to a file a claim. To be eligible, your claim must be initiated **within 15 days** from your last day worked.

***** Please return original forms to the Plan Office *(fax/photocopy/scan not accepted)*. *****

1. ELIGIBILITY FOR WEEKLY DISABILITY BENEFITS

You are eligible to apply for Weekly Disability Benefits if you are eligible for Health & Wellness benefits at the time the disability occurs, are under the immediate and personal care in Canada of a physician and **you are not retired (i.e. not receiving a retirement pension)**.

If you elect to receive a retirement pension, including Shortened Life Expectancy, while you are receiving disability benefits, your eligibility for the Weekly Disability Benefit will cease.

All of the required forms must be fully completed before your claim can be assessed.

If a member **is not eligible** at the time a disability occurs, the Plan **will not pay** any benefits in respect of the disability. A member's eligibility must be maintained to continue to receive Weekly Disability Benefits which may require self-payments for up to 6 months. You will be notified when the self-payment option applies to you.

2. ELIGIBLE DISABILITIES

The Plan provides benefits to members who qualify with any disability resulting from an illness or accident that prevents you from performing your regular work. **Weekly payments will not be paid for a disability:**

a) where benefits are available to you under the *Workers' Compensation Act* or an equivalent law, or
b) which was self-inflicted while sane or insane, or
c) which occurs while you are receiving a retirement pension from a pension plan, or
d) which occurs while you are in receipt of total temporary disability benefits from Workers' Compensation even if the illness or injury is not related, or
e) if you are disabled as a result of illness and you have previously received the maximum 26 weeks of disability benefit payable for an illness within a 24-month period, or
f) which occurs while in commission of a criminal offence or while resisting arrest, or
g) has not been submitted to the Plan Office within 15 days of your last day worked, or
h) where a Shortened Life Expectancy lumpsum pension benefit has been paid.

3. BENEFITS

The Weekly Disability Benefit is currently set at $550.00 (less applicable taxes) per week payable from the **1st day of non-occupational disability resulting from an accident** (the event which caused you to stop working and seek immediate medical attention) and from the **8th day of disability resulting from illness** and are initially payable up to a two-week period.

It is expected that you will also apply for Employment Insurance (EI) Sick Benefits if your disability will continue for more than 2 weeks.

The Plan provides a maximum of 26 weeks of Weekly Disability. A maximum of 26 weeks of Weekly Disability will be paid during a 24-month period for disabilities which occur as a result of an illness.

Disabilities for substance abuse/addiction require proof of enrolment, as well as ongoing enrolment at a qualified treatment centre. You must provide these details with your initial claim.

If you continue to be disabled and qualify for Sick Benefits from Employment Insurance after the first two weeks of disability, you will receive disability benefits for a maximum of 24 weeks from the date you no longer qualify for Employment Insurance Sick Benefits.

If you continue to be disabled and **do not qualify** for Sick Benefits from Employment Insurance after the first two-weeks of disability, you can receive the remainder of the 26 week maximum of weekly disability payments. **You must provide proof that you do not qualify for Employment Insurance Benefits**.

Disability Benefits cease if you cease to be disabled or you start receiving a retirement pension from a Pension Plan, or receive a lumpsum payment due to a Shortened Life Expectancy approval.

4. SUBSEQUENT DISABILITIES

Your disability will be considered a new disability and you will be entitled to Weekly Disability Benefits again only if:

1. You have returned to covered employment (working for a Participating Employer) or are available for active full-time employment at your regular work for at least 3 working days, and
2. You have had a least 130 Hours of confirmed employment within 6 months from your last disability payment, and
3. You have recovered from your first disability and the subsequent disability is not connected to any previous disability.

In all events the Plan has the right to deny any claim which appears to be connected to a prior disability and coverage has been previously provided.

If you have been receiving disability payments, you must provide to the Plan written certification from your doctor indicating the date that you are fit to return to regular work.

Unless this confirmation has been submitted to the Plan, your subsequent disability will not be considered a new disability.

5. MAINTAINING ELIGIBILITY WHILE DISABLED

A member who is in good Union standing at the time of his disability, who is receiving Weekly Disability Benefits from the Plan, sickness benefits from the *Employment Insurance Act*, disability benefits from *Workers Compensation Act* or a disability pension from the ACAW Pension Plan, the Canada Pension Plan or privately retained disability insurance, shall not have the 130 Hours deducted from their Hour Bank until the month following the member's attainment of:

1. Age 60, if the member was age 55 or older as at January 1, 2015 and eligible to commence an unreduced pension (i.e. no early retirement reduction), or
2. Age 65, if the member was under age 55 as at January 1, 2015.

A member's eligibility must be maintained to continue to receive Weekly Disability Benefits which may require self-payments in some circumstances.

6. COMPLETION OF MEDICAL REPORTS

Medical examinations must be performed in Canada by a medical doctor (MD) licensed to practice in Canada. You will be required to provide periodic reports of your progress and may be assessed by the Plan's Medical Consultant.

You are responsible for any costs related to the completion of forms.

When you recover or return to work or receive a retirement pension from a pension plan, it is important that you notify the Plan Office immediately to avoid overpayment of benefits.

7. RECOVERY COST FROM A THIRD PARTY

As a "Trust Fund" the Plan retains the right to recover benefits paid if you become disabled due to an injury or illness for which a Third Party is or may be liable. You must complete and sign the Recovery Costs from a Third Party section on the Members Statement.

You will be required to reimburse the Plan in accordance with the terms and conditions stated.

You must obtain the written consent of the Trustees before compromising or settling the action or cause of the action with the Third Party. **Failure to obtain the consent of the Trustees will disentitle you to future benefits under the Plan and will relieve the Trustees of the Plan of all of their obligations to you.** The Trustees shall not unreasonably withhold consent.

8. CANADA PENSION PLAN (CPP) / WORKERS' COMPENSATION BOARD (WCB) DISABILITY

If your disability continues for longer than **3** months and can be considered severe and prolonged, it is expected that you will submit an application for a Canada Pension Plan (CPP) disability pension at that time. Often CPP disability pensions are granted on a retroactive basis.

Should you apply and be approved for a CPP/WCB disability pension any payment received while receiving WD from the Plan will be required to be refunded to the Plan. You will be required to provide information to the Plan Office on the status of your CPP application until a decision is received.

9. TAXATION

Weekly Disability payments constitute taxable income. Members are responsible to report the income when filing their personal income tax and tax will/may be payable at that time. If you move, please ensure your Local Union has your new address.

A T4A will be issued at year-end.

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ACAW HEALTH & WELLNESS PLAN • **APPLICATION FOR WEEKLY DISABILITY BENEFITS** • *MEMBER'S STATEMENT*

→"Disability" means a non-occupational illness or injury that prevents a member from performing his/her regular work.
→ Before proceeding to make a claim, please refer to the *"2. Eligible Disabilities"* section (see **page 1** of this document).
→ It is imperative that you answer all questions as any missing information will delay the processing of your claim.

***** Please return original forms to the Plan Office *(fax/photocopy/scan not accepted)*. *****

1. CLAIMANT IDENTIFICATION *(PLEASE PRINT)*

Last Name _____ First Name _____ Mid. Initial _____ Date of Birth ____ / ____ / _____ MM / DD / YYYY

Address (Apt# / Street / PO Box) _____ Home Telephone Number _____

City _____ Province _____ Postal Code _____ Union ID No. _____ **or** Social Insurance No. _____

2. NATURE OF THE DISABILITY *(YOU MUST FULLY COMPLETE EACH QUESTION)*

I am a member of: ☐ local 1325, 2103 or 2010 ☐ Office Staff ← **Please select ONE (only)**

A. What is the nature of your present disability? _____

Have you made a claim for this disability or a previous disability in the last 2 years? ☐ Yes ☐ No

B. Please give the date your present illness began, **or** the date your injury occurred: Month ____ Day ____ Year _____ MM / DD / YYYY

C. If your disability is a **result** of an injury, describe **where** and **how** it occurred: _____

D. When was the end of your last shift worked: Month ____ Day ____ Year _____ MM / DD / YYYY

Have you attempted to do any work since this date? ☐ Yes ☐ No → If **yes**, provide details: _____

3. RECOVERY COSTS FROM A THIRD PARTY *(YOU MUST ANSWER EACH QUESTION)*

A. If this claim is as a result of an injury you must complete the following. Before proceeding, please refer to the *"7. Recovery Cost from a Third Party"* section (see **page 2** of this document).

I, _____ do hereby state that, as a result of my disability, a claim has been made, or should a claim be made, against a Third Party. I understand that any payment made to me by the ACAW Health & Wellness Plan (the Plan) as a result of this disability is considered "an advance".

In consideration of receiving benefits from the Plan I, _____, agree to fully reimburse the Plan from any monies I receive from any third party, insurer, or other source whatsoever arising out of the matter for which I received the benefits and that I fully understand the reimbursement shall be free of any deductions for any expense I may have incurred to recover same.

→ Member's Signature

← Required for all injury claims

Date **MM** / **DD** / **YYYY**

B. Are you receiving or have you applied for Disability Benefits from any source below (select **all** that apply):

CANADA PENSION PLAN	☐ Receiving	☐ Applied	☐ Neither
WORKERS' COMPENSATION	☐ Receiving	☐ Applied	☐ Neither
EMPLOYMENT INSURANCE	☐ Receiving	☐ Applied	☐ Neither
RETIREMENT PENSION	☐ Receiving	☐ Applied	☐ Neither
PRIVATELY RETAINED DISABILITY INSURANCE	☐ Receiving	☐ Applied	☐ Neither

To view the 2-page PDF, titled: **"ISP-1618(A-B) - Service Canada - Insurer: Disability Benefits Retroactive Payment and Information Sharing Consent"**, visit: **https://catalogue.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=ISP1618A-B**

If you have indicated that you are "**Receiving**" to any of the above, please provide the following information:

Name of Program	Payment Amount	Payment Date (Began)	Payment Date (Ended)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

If you have indicated that you have "**Applied**" to any of the above, please provide name of program and date applied:

_____

Please provide copies of any correspondence from CPP, EI or WCB.

C. Have you any other source of income **not** mentioned above? ☐ Yes ☐ No → If **yes**, provide details:

_____

_____

_____

4. MEMBER'S DECLARATION

I have read the enclosed information regarding Weekly Disability and I hereby apply for Weekly Disability Benefits from the ACAW Health & Wellness Plan.

I hereby declare that the above answers, statements and additional information, if any, given by me are complete, true, and correctly recorded to the best of my knowledge and belief.

I hereby consent, authorize and direct every physician, surgeon, or any other person who has examined me and every hospital or other institution to which I have applied for, or in which I have received treatment, to disclose to the Plan or its Trustees throughout the duration of this claim, any knowledge or information thereby acquired.

I understand this is a taxable benefit and income tax receipts will be issued in the new year.

→

Member's Signature *(fax/photocopy/scan not accepted)*

← Required for all claims

Date **MM** / **DD** / **YYYY**

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ACAW HEALTH & WELLNESS PLAN • **DISCLOSURE CONSENT** • *AUTHORIZATION FORM*

Date: _____

To Whom It May Concern:

RE: ACAW Health & Wellness Plan Weekly Disability Benefit Claim

I hereby expressly consent, authorize and direct:

- Workers' Compensation Board
- Employment Insurance
- Canada Pension Plan
- Current or prior employers
- Medical practitioners I have attended
- My Local of the United Brotherhood of Carpenters & Allied Workers
- A center for treatment of addictions that I have attended or will attend
- Privately Retained Disability Insurance

to disclose any knowledge and information requested by the ACAW Health & Wellness Plan, in respect to my Weekly Disability Benefit Claim.

My signature below also acknowledges that I am aware that, if my condition involves substance abuse/addictions, I must provide proof of enrolment and attendance at a treatment center.

Member's Signature *(fax/photocopy/scan <u>not</u> accepted)*	Print Name Here
Street Address	Union ID No. **<u>or</u>** Social Insurance No.
City/Province/Postal Code	Phone Number

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ACAW HEALTH & WELLNESS PLAN • # ELECTRONIC DEPOSIT OF WEEKLY DISABILITY PAYMENT • *PAYMENT INFORMATION*

→ All Weekly Disability payments from the ACAW Health & Wellness Plan will be electronically deposited to your bank account.
→ Please complete this electronic deposit form and **return the original**.

***** Please return original forms to the Plan Office *(fax/photocopy/scan not accepted).* *****

1. CLAIMANT IDENTIFICATION *(PLEASE PRINT)*

Member's Last Name | Member's First Name | Mid. Initial | Date of Birth MM / DD / YYYY

Address (Apt# / Street / PO Box) | Home Telephone Number

City | Province | Postal Code | Union ID No. | **or** | Social Insurance No.

2. PERSONALIZED VOID CHEQUE

Please attach a **PERSONALIZED void cheque.** Generic cheques **will not** be accepted.
If you **do not** have a "personalized" cheque to provide, please have your Bank complete the next section of this form.

3. IF A PERSONALIZED VOID CHEQUE IS NOT AVAILABLE *(PLEASE PRINT)*

If you are providing information for a "savings" account, or **cannot** provide us with a "personalized" void cheque, please have your bank complete and sign this section:

Institution Number (3 Digits) | Transit Number (5 Digits) | Account Number (5 To 11 Digits)

I certify that this: ☐ **Chequing account** ☐ **Savings account** *(Select one)*
information is registered at our institution under the name of the person identified at the top portion of this form.

Name of Bank Employee

→ Bank Employee's Signature *(fax/photocopy/scan not accepted)*

Telephone Number

Date MM / DD / YYYY

4. AUTHORIZATION BY ACAW MEMBER

I hereby certify that the above answers are full and true to the best of my knowledge and belief and authorize the ACAW Health & Wellness Plan to make electronic deposits of granted weekly disability payments to my bank account, as described on this page.

→ Member's Signature *(fax/photocopy/scan not accepted)*

Date MM / DD / YYYY

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ACAW HEALTH & WELLNESS PLAN • **APPLICATION FOR WEEKLY DISABILITY BENEFITS** • *PHYSICIAN'S STATEMENT*

→ To be completed by a physician.
→ **ATTENTION PHYSICIAN**: Please provide sufficient details of history, investigation, findings and treatment to offer maximum help to the Claimant in establishing the validity of this claim. **Any fee for completion of this form is the responsibility of the patient.**
→ "Disability" means a non-occupational illness or injury that prevents a member from performing his/her regular work.

***** Please return original forms to the Plan Office *(fax/photocopy/scan not accepted)*. *****

1. CLAIMANT IDENTIFICATION *(PLEASE PRINT)*

Member's Last Name | Member's First Name | Mid. Initial

Address (Apt# / Street / PO Box) | Date of Birth MM / DD / YYYY

City | Province | Postal Code | Home Telephone Number

2. TREATING PHYSICIAN *(PLEASE PRINT)*

Physician's Last Name | Physician's First Name | Mid. Initial

Address (Apt# / Street / PO Box) | Telephone Number

City | Province | Postal Code | Fax Number

3. HISTORY *(PLEASE PRINT)*

This person been my patient since: Month ____ Day ____ Year ____ MM / DD / YYYY

Date of first consultation for this disability: Month ____ Day ____ Year ____ MM / DD / YYYY

Date of most recent visit: Month ____ Day ____ Year ____ MM / DD / YYYY

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____ *(Specify)*

The **exact** date this disability commenced *(a specific date must be given)*: Month ____ Day ____ Year ____ MM / DD / YYYY

Was or is surgery involved? ☐ Yes ☐ No → If **yes**, please provide date: Month ____ Day ____ Year ____ MM / DD / YYYY

Has the Claimant ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

Was injury or illness work related? ☐ Yes ☐ No ☐ Unknown → If **yes**, was a claim made to WCB? ☐ Yes ☐ No ☐ Unknown

4. DIAGNOSIS *(INCLUDING ANY COMPLICATIONS)*

A. Primary:

Secondary:

B. Are there any other factors affecting recovery? ☐ Yes ☐ No → If **yes**, please explain:

C. Investigations/test results (please include dates):

D. Medications ☐ Yes ☐ No → If **yes**, please list and describe:

5. PHYSICAL AND MENTAL CAPACITIES ASSESSMENT

The Claimant is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Functional Capacity:
- ☐ No limitation of functional capacity; capable of **strenuous** activity
- ☐ Minimal limitation of functional capacity; capable of **moderate** activity
- ☐ Medium limitation of functional capacity; capable of **light** activity
- ☐ Severe limitation of functional capacity; incapable of **minimal** activity

6. PROGNOSIS *(AN ESTIMATED REMAINDER OF DISABILITY DURATION IS REQUIRED)*

Impairment Is: ☐ Temporary → Complete "**A**" & "**B**" below ☐ Permanent → Complete "**A**" below (Ignore "**B**")

A. Can patient perform essential tasks of his/her occupation? ☐ Yes, **able** to perform essential tasks ☐ No, **unable** to perform essential tasks

Or any other occupation? ☐ Yes, **able** to perform other occupation ☐ No, **unable** to perform other occupation

B. In your opinion when will the patient be able to return to regular employment?

_____ Weeks _____ Months ☐ Never Other comments: _____

PLEASE NOTE: Estimated duration of disability must be given in order for the Plan to assess approximate length of benefit payments.

7. SIGNATURE OF PHYSICIAN

I hereby certify that the above answers are full and true to the best of my knowledge and belief.

→ _____

Physician's Signature *(fax/photocopy/scan not accepted)*

Date MM / DD / YYYY