WEEKLY INDEMNITY CLAIM FORM

Company Name: This form should be submitted as soon as possible after completion of the waiting period. Please print clearly and instruct your doctor to print clearly. Please notify BENEPLAN or advise your employer to notify BENEPLAN as soon as you return to work.	Submit your form to your employer or directly to: Weekly Indemnity Claims **Beneplan Inc.** 500-150 Ferrand Drive Toronto, ON M3C 3E5 disability@beneplan.ca 416-863-6718 (1800-387-1670) Fax 416-863-5157

PART 1 - EMPLOYEE'S STATEMENT: Full Name:		Home Address: City: Province: Postal Code: Email (optional)	
Date of Birth: DD/MM/YYYY	Gender: ☐ Male ☐ Female	Social Insurance Number:	Telephone Number: Alternate Phone:
Occupation:		Job Description: (Include physical labour requirements, i.e. heavy lifting, etc.):	
Complete if disability is a result of an accident: Date of Accident (DD/MM/YYYY): Time of Accident: hour_____ ☐ a.m. ☐ p.m.		Location of Accident: (home, work, other specify):	
Describe briefly the nature of your illness of accident:			
Complete if motor accident: Province accident occurred:		Are you receiving or have you applied for disability benefits from any automobile insurance company? If "yes", how much are you receiving per week? $ _____	

I certify that the statements above are true; I hereby authorize any licensed physician, medical practitioner, hospital or any other medical facility or related person that has any medical information of any type to release such information as requested by BENEPLAN as administrator for my employer.

I authorize the use of my social insurance number for the administration and taxation of the benefits payable. I authorize BENEPLAN to withhold tax from any amounts payable as per the TD1 filed with my employer.

Employee's Signature: _____Date: _____