beneplan

WEEKLY INDEMNITY CLAIM FORM

EMPLOYEE'S AUTHORIZATION:
I, the undersigned, hereby authorize the release to BENEPLAN as administrator for my employer, any information relevant to my claim herein.

Name in full (please print):

ATTENDING PHYSICIAN'S STATEMENT:

<table>
<tr><td colspan="2">ATTENDING PHYSICIAN'S STATEMENT:
Patient's name:</td><td colspan="2">Full Address:

Email Address:

Tel. #: Fax#</td></tr>
<tr><td colspan="4">Primary diagnosis of present situation:</td></tr>
<tr><td colspan="4">Additional conditions that might affect the claimant's ability to work:</td></tr>
<tr><td colspan="4">To the best of your knowledge, when did the claimant's symptoms first appear?

To the best of your knowledge, did the claimant have similar symptoms in the past? ☐ Yes ☐ No

If "yes", state the date:</td></tr>
<tr><td colspan="3">Did the present condition arise due to the claimant's work or occupation?

☐ Yes ☐ No Explain, if necessary:</td><td>If the claimant was/is pregnant, indicate date or expected date of delivery:</td></tr>
<tr><td colspan="4">Date of patient in-hospital treatment: Date of expected discharge:

Nature of treatment:</td></tr>
<tr><td colspan="3">Are you the primary caregiver? If not, please indicate the full name of the primary care giver below.</td><td>If you have referred the patient to a specialist, please state the name and telephone number:

Full name:

Tel. #:</td></tr>
<tr><td>Date of first visit for the condition that resulted in this claim:</td><td colspan="2">Date of last attendance:</td><td>Date of next visit and frequency of future visits, if applicable:</td></tr>
<tr><td colspan="4">Please state, in your professional opinion, how the claimant's current condition affects his/her ability to work, (i.e. limitations, constraints, etc.)</td></tr>
<tr><td colspan="3">If, in your opinion, the claimant is unable to perform his/her normal work, is he/she able to perform lighter work? If so, please describe:</td><td>Date when, in your professional opinion, the claimant will be able to perform his/her normal work:</td></tr>
<tr><td colspan="4">I certify that the statements above are true. I understand that any charges for completing this form are the claimant's responsibility.
Attending Physician's Signature: ______________________________ Date: ________________</td></tr>
</table>

Please return to: disability@beneplan.ca / Fax 416-863-6718 / Beneplan Disability 500-150 Ferrand Dr Toronto ON M3C3E5 / 1-800-387-1670