WEEKLY INDEMNITY CLAIM FORM

Beneplan Inc

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 416-863-6718 (1800-387-1670) Fax 416-863-5157

EMPLOYEE'S STATEMENT: Full Name:		Full Address: City: Province: Pcode:	
Date of Birth: DD/MM/YYYY	Sex: ☐ Male ☐ Female	Social Insurance Number:	Telephone Number:
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: _____

EMPLOYER'S STATEMENT:
(The employer must complete this section **after** it has been completed by the employee.)

Weekly Salary: $ _____ Employee's last day at work prior to disability: _____

To your knowledge, is the disability related to his/her occupation: ☐ Yes ☐ No	Is the employee covered by Workers' Compensation? ☐ Yes ☐ No	Has a Workers' Compensation claim been made or will it be made? ☐ Yes ☐ No
Do you know of any reason why this claim should **not** be paid?		Complete only if the benefit is taxable: Personal tax exemption per TD1: ☐ Federal $ _____ ☐ Provincial $ _____
Other comments:		
SIGNED ON BEHALF OF EMPLOYER: (Print name clearly) Name: Signature: Position/Title:		Date completed: (DD/MM/YYYY) Telephone Number: Fax Number:

Please turn over

ATTENDING PHYSICIAN'S STATEMENT SECTION:

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):

<table>
<tr><td>ATTENDING PHYSICIAN'S STATEMENT:
Patient's name:</td><td colspan="3">Full Address:

City: Province: Postal Code:

Tel. #:</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>
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