

Dear UNITE HERE Local 47 Member:

Re: Accident & Sickness (Wage Loss) Benefit

The purpose of this letter is to provide you with the information necessary to file your claim for Accident & Sickness (wage loss) benefits with the Plan Administrator

As per your request an accident and sickness benefit claim form has been sent to you which should be fully completed and returned to the Office of the Administrator for further processing.

Failure to return the completed Accident and Sickness Claim Form to the Office of the Administrator within four (4) weeks of the date of this letter could result in the loss of benefits.

The amount of your accident and sickness benefit will be 75% of your gross weekly earnings established over the most recent three consecutive month period immediately prior to your month of claim to the weekly maximum that is outlined in the Health Care Plan Text.

A maximum accident and sickness benefit payment of 45 weeks may be possible and is derived as follows:

- (1) An initial maximum 15 week payment period less the applicable deductible from the Health Care Plan.
- (2) A maximum additional 15 week payment period from Employment Insurance (EIC) Canada.
- (3) A further maximum 15 week payment period from the Health Care Plan.

Under the terms of this Health Care Plan payment for any 1 ailment is limited to a maximum of 30 weeks.

Please note that the accident and sickness (wage loss) benefit is a taxable benefit. You will receive from this office a T4A for the amount of benefit received during this calendar year, sometime between January 15th and February 28th, of the following year.

Effective January 1, 2005 all UNITE HERE Local 47 Health Care Plan wage loss benefit claims where Stress, Anxiety or Depression is diagnosed as the disabling medical condition, must be supported by written evidence from Human Solutions (formerly Wilson Banwell), satisfactory to the Board of Trustees, that a course of treatment with Human Solutions "Employee and Family Assistance Program" has commenced or is scheduled to commence with a brief description of the proposed course of treatment and its anticipated duration.

When the claim form has been fully completed mail to:
A.R.M. Management Ltd., #201 4853 Hastings Street, Burnaby, BC, V5C 2L1

Counselling services provided by Human Solutions “Employee and Family Assistance Program” are available at no cost to members of UNITE HERE Local 47 and the Board of Trustees encourages Local 47 members to utilize the broad range of counselling services offered by Human Solutions to address personal difficulties.

Human Solutions can be contacted at one of the following telephone numbers; 1-800-663-1142 or 403-216-6340, and we encourage you to contact them as soon as possible regarding their services and secure the required letter from Human Solutions with a brief description of the proposed course of treatment and the anticipated duration, and forward that letter to our office.

Should you have any question regarding this claims procedure, please do not hesitate to contact the office of the Plan Administrator by calling toll free 1-800-661-2766 or email sandra_reilly@armmanagement.ca

Yours very truly,
A.R.M. Management Ltd.
Plan Administrator for the
Board of Trustees

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SECTION 4 ATTENDING PHYSICIAN'S INITIAL STATEMENT - PLEASE RETURN COMPLETED FORM TO YOUR PATIENT

1. Patient's Name and Address		Date of Birth:
2. Diagnosis of present disabling condition		
3. Additional conditions which might affect the duration of disability		
4		
a.	Date of first visit related to present disability	Mo. _____ Day _____ 20____
b.	Date of last attendance	Mo. _____ Day _____ 20____
c.	Were you actively supervising this patient's care during the full period <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. If the patient is pregnant what is the expected date of confinement?		
		Mo. _____ Day _____ 20____
6. Date Hospitalized (From - To)	7. If Surgery Performed, Please indicate date of surgery and describe:	8. If referred to you, give name of referring physician
Mo. _____ Day _____ 20____		
Mo. _____ Day _____ 20____		
9. (a) To the best of my knowledge, the patient has been TOTALLY disabled (unable to perform regularly scheduled employment)		
From: Mo. _____ Day _____ Yr _____ to Mo. _____ Day _____ Yr _____ inclusive		
9. (b) If still disabled give approximate date patient should be able to return to regularly scheduled employment.		
Mo. _____ Day _____ Yr _____		
10. How long was or will the patient be TOTALLY DISABLED?		
From: Mo. _____ Day _____ Yr _____ to Mo. _____ Day _____ Yr _____ inclusive		
11. To the best of my knowledge		
(a) Symptoms first appeared or accident happened	Mo. _____ Day _____ Yr _____	
(b) Patient has had same or similar condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, state when and describe		
REMARKS:	Physician's Name (Please print)	Dr. No.
	Address	Telephone No.
	Signature	Date

MEDICAL RELEASE AUTHORIZATION

I hereby authorize the release to my insurer or any information requested in respect of this claim.

_____ Date _____ Signature of Patient

The patient is responsible for securing this form and for charges made for its completion