

Effective June 1, 2002 Trustees require all eligible persons to apply for accident and sickness benefits from this Health Care Plan as well as from Human Resources Development (EI) Canada, as soon as possible.

Please complete the enclosed Accident and Sickness Claim Form and return it to the Office of the Administrator as soon as feasible.

Please find outlined below the revised claims procedure that all claimants should follow:

- (A)** All eligible persons should apply for accident & sickness benefits from this Health Care Plan as well as from Human Resources Development (EI) Canada as soon as possible.
- (B)** During the initial two (2) week Human Resources Development (EI) Canada waiting period all eligible persons will receive accident and sickness (wage loss) benefits from this Health Care Plan for the period of time they qualify (maximum initial payment = 14 days, less any applicable waiting period).
- (C)** All insured and eligible persons who continue to be ill for a period greater than 14 days must now approach Human Resources Development (EI) Canada for accident & sickness benefits payable for a maximum period of fifteen (15) weeks.
- (D)** Those eligible persons who continue to be ill, who have qualified for Human Resources Development (EI) Canada sickness benefits and who have received their maximum EI sickness benefit, may qualify for additional accident and sickness benefits from the BCHA UNITE HERE Local 40 and/or UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan.

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 % for a Group One participant and 55% for a Group Two participant of your gross weekly earnings established over the most recent three (3) consecutive month period immediately prior to your month of claim to the maximum that is outlined in the Health Care Plan information booklet.

Please note that the accident and sickness (wage loss) benefit is a taxable benefit. No income tax will be withheld. You will receive a T4A for the amount of benefit received during this calendar year, sometime between January 15th and February 28th, of the following year.

Should you have any questions regarding your coverage please do not hesitate to contact the A.R.M. Management Ltd., Leanne Colley at 604-294-4441, Ext. 228 or email her [leanne\\_colley@armmanagement.ca](mailto:leanne_colley@armmanagement.ca)



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

**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

<b>MEDICAL RELEASE AUTHORIZATION</b>	
I hereby authorize the release to my insurer 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*