THE EDMONTON PIPE INDUSTRY

HEALTH, WELFARE & PENSION TRUST FUNDS

16214 118 AVENUE EDMONTON ALBERTA T5V 1M6
Tel (780) 452-1331 Fax (780) 487-4063 EMAIL: questions@epibenefitplans.com WebSite www.epibenefitplans.com

WITHOUT PREJUDICE

THE EDMONTON PIPE INDUSTRY HEALTH & WELFARE PLAN WEEKLY DISABILITY BENEFIT

Dear Member,

Please see enclosed forms for you and your physician to complete and return to the Benefit Administration Office. Please ensure that the Attending Physician's Statement is filled out by your Family Doctor or a Specialist (NOT a Psychologist / Chiropractor / Physiotherapist / Nurse Practitioner / Mid Wife).

These forms must be completed and submitted within 60 days of your date of disability for you to be eligible for benefits.

The Plan's Weekly Income benefits are taxable and income tax will be deducted from Weekly Income payments. Please complete the enclosed TD-1 forms and submit them along with your disability forms. If the TD-1 forms are not submitted, it will be assumed that there are no other deductions to be considered. **Effective with disabilities arising on/after July 1, 2024**, the weekly disability amount will match the Employment Insurance Sick Benefit maximum. The benefit amount will be updated each January 1st. **Effective January 1, 2025, the weekly amount is $695.00 per week.** This amount will be taxed in accordance with the Canada Revenue Agency Payroll Deduction Calculator and your province of residence.

When applying for the Weekly Disability Benefit, you should also apply for Employment Insurance (EI) - Sickness Benefits. There is a 1 week waiting period for the EI Sickness Benefits to commence. The Plan may provide Weekly Income benefits during this waiting period if the disability is due to an accident or injury not related to a WCB claim or motor vehicle accident.

PLEASE NOTE: If you are not eligible for EI Sickness Benefits, please provide the Administration Office with a copy of the denial letter. The Plan's Weekly Disability benefits will be payable during the 26 week period normally covered by EI Sickness Benefits if those Benefits have been denied.

The Weekly Income Benefit is 26 weeks in duration, inclusive of the 26 weeks from EI. If you did not receive the full 26 weeks from EI Sickness Benefits, contact the Administration Office to assess if you are eligible to start receiving Weekly Income from the Plan.

If your disability will continue after the 26 weeks, you will apply for Long Term Disability, which must be applied for within one year from the date of disability.

If your disability is due to your employment, as specified by your physician, the Plan will refer you to WCB to start a claim. If you are denied by WCB, the Plan will require a copy of the denial letter to further review your claim. If you are approved by WCB, please contact the Administration Office to inquire about possible benefit waivers.

No Weekly Disability benefits payment will be made for any disability arising from a motor vehicle accident for which the member is receiving, or is entitled to receive, and income replacement or loss of earning capacity benefit.

If your disability is due to substance abuse the plan requires proof of a recognized substance withdrawal program before any benefits are paid.

Once all initial forms are received, the Administration Office will send a letter via mail confirming the next steps. If you are cleared for a return to work, it is your responsibility to communicate the date to the Administration Office as soon as possible as disability payments will cease one day prior to your return to work.

If approved for the Weekly Disability benefit, the Plan may grant you disability waivers to continue your coverage on the Health & Welfare Plan for a maximum of 24 months after which you will be able to self pay.

A Benevolent Fund Application is enclosed for you to apply for Union Dues waivers. Eligibility for Union Dues waivers are at the sole discretion of the UA Local 488 Benevolent Committee.

If your disability is severe, we encourage you to apply for the Disability Tax Credit with Canada Revenue Agency and Canada Pension Plan Disability benefits. Please reference the government's website for more information.

Please note that the Weekly Disability benefit is an uninsured benefit and is not underwritten by a Contract of Insurance. Benefits are solely supported by the assets of the Health & Welfare Trust Fund.

If you have any questions, please do not hesitate to contact the Benefits Administration Office.

Best regards,

Benefit Administration Office Tel: 780-452-1331
Fax: 780-487-4063

Enclosed

THE MEMBER IS RESPONSIBLE FOR CHARGES INCURRED FOR THE COMPLETION OF THE ATTENDING PHYSICIAN STATEMENT AND ANY OTHER REQUIRED MEDICAL DOCUMENTATION

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

WEEKLY DISABILITY BENEFIT CLAIM

INSTRUCTIONS: 1. Complete Part 1, and sign form where indicated for Parts 1 and 2.
2. Have your doctor complete Part 2 on the back of this form.
3. Return the completed form to:

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
16214 - 118 AVENUE, EDMONTON, ALBERTA T5V 1M6
TELEPHONE: 780-452-1331

4. Completed claims must be submitted within 60 days of the date on which total disability commenced. Late filed claims will be declined.

PART 1 - MEMBER'S STATEMENT

1. NAME

2. SOCIAL INSURANCE NUMBER

3. ADDRESS

CITY PROVINCE POSTAL CODE

4. DATE OF BIRTH ____ | ____ | ____ (YEAR MONTH DAY) SEX ☐ MALE ☐ FEMALE

5. HOME TELEPHONE NUMBER

6. NAME OF LAST OR CURRENT EMPLOYER

7.
A. DATE EMPLOYMENT COMMENCED ____ | ____ | ____ (YEAR MONTH DAY)
B. DATE LAST WORKED ____ | ____ | ____ (YEAR MONTH DAY)

8. REASON FOR LEAVING: LAYOFF ☐ ILLNESS ☐ ACCIDENT ☐ OTHER ☐ _____

9. BRIEF DESCRIPTION OF JOB DUTIES

_____

_____

10. DATE TOTAL DISABILITY COMMENCED ____ | ____ | ____ (YEAR MONTH DAY)

11. DATE OF EXPECTED RETURN TO WORK ____ | ____ | ____ (YEAR MONTH DAY)

12. IF DISABILITY IS DUE TO AN ACCIDENT, PLEASE INDICATE: (A) DATE AND TIME OF ACCIDENT

____ | ____ | ____ (YEAR MONTH DAY) AT____ AM ☐ PM ☐

(B) IS THE DISABILITY A RESULT OF A MOTOR VEHICLE ACCIDENT? YES ☐ NO ☐

(C) DID ACCIDENT OCCUR AT WORK? YES ☐ NO ☐

(D) DETAILED DESCRIPTION OF ACCIDENT AND HOW IT HAPPENED (ATTACH PAGE IF MORE SPACE REQUIRED) _____

_____

13. ARE YOU NOW: HOUSE CONFINED ☐ BED CONFINED ☐ HOSPITAL CONFINED ☐ AMBULATORY ☐ WORKING ☐

14. IF CONFINED TO HOSPITAL: NAME OF HOSPITAL _____

DATE AND TIME ADMITTED ____ | ____ | ____ (YEAR MONTH DAY) AT____ AM ☐ PM ☐

DATE AND TIME DISCHARGED ____ | ____ | ____ (YEAR MONTH DAY) AT____ AM ☐ PM ☐

15. ARE DISABILITY BENEFITS PAYABLE FROM ANY OTHER SOURCE AS THE RESULT OF THIS SICKNESS OR INJURY? YES ☐ NO ☐

IF "YES", GIVE NAME OF SOURCE AND DETAILS. _____

16. STATE BRIEFLY DAILY ROUTINE SINCE LEAVING WORK. MENTION ANY LIGHT TASKS YOU ARE ABLE TO PERFORM.

_____

_____

17. NAMES AND ADDRESSES OF ALL DOCTORS CONSULTED DURING PRESENT DISABILITY.

_____

_____

18. I hereby warrant that the information contained on this form is true and complete to the best of my knowledge and belief. I authorize use of my Social Insurance Number for claim identification purposes only. I understand that the information I provide will be protected pursuant to the relevant legislation. I authorize the Board of Trustees, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited. I acknowledge that benefits under this Plan are integrated with Employment Insurance (E.I.) Sickness Benefits, and I must provide documentation from E.I. if I have exhausted or do not qualify for E.I. Sickness Benefits. I further acknowledge that no benefit is payable for any period during which I engage in work at any occupation for remuneration or profit (other than as part of an approved rehabilitation program).

DATE _____ 20 _____ SIGNATURE OF MEMBER _____

THIS BENEFIT IS NOT INSURED. DISABILITY BENEFITS ARE FUNDED SOLELY BY THE ASSETS OF THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND.

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. PATIENT'S NAME

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING: (A) OUT OF PATIENT'S EMPLOYMENT YES ☐ NO ☐ UNKNOWN ☐
   (B) FROM A MOTOR VEHICLE ACCIDENT YES ☐ NO ☐

3. DIAGNOSIS OR PRESENT CONDITION
   (A) PRIMARY
   (B) SECONDARY (IF APPLICABLE) OR ADDITIONAL CONDITIONS WHICH MIGHT AFFECT DURATION OF DISABILITY

4. TO THE BEST OF MY KNOWLEDGE
   (A) SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED ____ YEAR ____ MONTH ____ DAY
   (B) PATIENT HAS HAD SAME OR SIMILAR CONDITION YES ☐ NO ☐
   (C) IF "YES", STATE WHEN AND DESCRIBE _____

5. DATE OF HOSPITAL IN-PATIENT ADMISSION ____ YEAR ____ MONTH ____ DAY
   DATE OF HOSPITAL OUT-PATIENT ADMISSION ____ YEAR ____ MONTH ____ DAY
   DATE OF HOSPITAL DISCHARGE ____ YEAR ____ MONTH ____ DAY
   ____ YEAR ____ MONTH ____ DAY

6. IF SURGERY WAS PERFORMED, ENTER DATE ____ YEAR ____ MONTH ____ DAY
   WAS GENERAL ANAESTHETIC ADMINISTERED? ____ YEAR ____ MONTH ____ DAY
   DESCRIPTION _____

7. IF REFERRED TO YOU, GIVE NAME OF REFERRING PHYSICIAN

8. (A) DATE OF FIRST VISIT FOR PRESENT PERIOD OF DISABILITY ____ YEAR ____ MONTH ____ DAY
   (B) DATE OF LATEST ATTENDANCE ____ YEAR ____ MONTH ____ DAY
   (C) WERE YOU ACTIVELY SUPERVISING THIS PATIENT'S CARE DURING THE FULL REPORT PERIOD? YES ☐ NO ☐
   IF "NO", PLEASE EXPLAIN _____
   IF "YES", STATE FREQUENCY OF VISITS WEEKLY ☐ MONTHLY ☐ OTHER ☐ (SPECIFY) _____
   NATURE OF TREATMENT _____

9. IF CONDITION IS DUE TO PREGNANCY, WHAT IS (OR WAS) THE EXPECTED DATE OF CONFINEMENT ____ YEAR ____ MONTH ____ DAY

10. HOW DOES PRESENT CONDITION AFFECT PATIENT'S ABILITY TO WORK?

11. (A) TO THE BEST OF MY KNOWLEDGE, THE PATIENT HAS BEEN TOTALLY DISABLED (UNABLE TO WORK)
    FROM ____ YEAR ____ MONTH ____ DAY TO ____ YEAR ____ MONTH ____ DAY INCLUSIVE
    (B) IF STILL DISABLED, GIVE APPROXIMATE DATE WHEN PATIENT SHOULD BE ABLE TO RETURN TO WORK ____ YEAR ____ MONTH ____ DAY
    OR, IF INDEFINITE, THE ESTIMATED NUMBER OF ADDITIONAL WEEKS BEFORE SUCH RETURN _____ ADDITIONAL WEEKS FROM TODAY.

12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ABLE TO WORK PART-TIME AT OWN OCCUPATION)
    FROM ____ YEAR ____ MONTH ____ DAY TO ____ YEAR ____ MONTH ____ DAY INCLUSIVE

PHYSICIAN'S NAME (PRINT)

ADDRESS

TELEPHONE NUMBER

SIGNED THIS _____ DAY OF _____ 20 _____ SIGNATURE OF PHYSICIAN (STAMP NOT ACCEPTED)

I HEREBY AUTHORIZE THE RELEASE TO THE PLAN ADMINISTRATOR ANY INFORMATION REQUESTED IN RESPECT OF THIS CLAIM.

SIGNED THIS _____ DAY OF _____ 20 _____ SIGNATURE OF PATIENT

THIS PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION.

Return the completed form to:
EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
16214 - 118 AVENUE, EDMONTON, ALBERTA T5V 1M6
TELEPHONE: 780-452-1331

UA LOCAL UNION 488

BENEVOLENT FUND
APPLICATION FOR BENEFITS

16214 - 118 Avenue - Edmonton, Alberta T5V 1M6
Phone: (780) 452-7080 Fax: (780) 452-1291
www.local488.ca

PLEASE PRINT CLEARLY - INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

NAME			SIN
ADDRESS			
CITY	PROVINCE		POSTAL CODE
HOME NUMBER ( )	CELL NUMBER ( )		
NATURE OF DISABILITY			
DATE OF DISABILITY MONTH / DAY / YEAR		DATE YOU EXPECT TO RETURN TO WORK MONTH / DAY / YEAR	
ARE YOU RECEIVING WCB BENEFITS?	YES ☐	NO ☐	
ARE YOU IN A RETRAINING PROGRAM?	YES ☐	NO ☐	
ARE YOU WAITING FOR SURGERY?	YES ☐	NO ☐	
ARE YOU APPLYING FOR CANADA DISABILITY BENEFITS?	YES ☐	NO ☐	
ARE YOU IN THE HOSPITAL NOW?	YES ☐	NO ☐	

The funding of the Local Union #488 Benevolent Fund is achieved by the Local Union diverting $0.50 (fifty cents) per member per month of your Union Membership dues in order to allow for the Funds operation. Please refer to the By-Laws and Working Rules Handbook for complete rules and history of the Benevolent Fund.

I hereby authorize the Members of the UA Local Union 488's Benevolent Committee to use and exchange information as needed for calculating and processing my claim under this fund with and including my Doctor (Physician), the Worker's Compensation Board and the Edmonton Pipe Industry - Health & Welfare Plan.

Member's Signature _____ Date _____

ALL APPLICATIONS FOR DISABILITY BENEFITS MUST BE ACCOMPANIED WITH THE APPROPRIATE DOCUMENTATION!

REFER TO PAGE 2 FOR APPLICATION INFORMATION

BENEVOLENT FUND
APPLICATION FOR BENEFITS

IMPORTANT INFORMATION TO REVIEW

- The Applicant must be a member in good standing of the Local Union in accordance with the United Association Constitution for a minimum period of three (3) months in order to be eligible for benefits from this Fund.
- The Applicant must be incapacitated or disabled for a period of more than thirty (30) days in order to receive benefits from this Fund.
- Proof of disability, sickness or accident, must be in writing from a medical Doctor (Physician) and must be included with your application for benefits. In addition the Committee will accept photocopies of medical certificates submitted by the Health and Welfare Office and/or letters signed by the Business Manager.
- All claims must be submitted to the Local Union Office within sixty (60) days of the of the period in which the claim may be payable.

THIS AREA FOR OFFICE USE ONLY

DATE OF GOOD STANDING	MEMBER'S DUES PAID TO
BENEFITS APPROVED FOR THIS PERIOD	
MONTHLY BENEFITS	$
CASH BENEFITS	$
TOTAL APPROVED	$
DISPOSITION OF FILE OPEN ☐ PENDING ☐ CLOSED ☐	
A) ADVISE MEMBER TO REAPPLY IF DISABLED AFTER ____ MONTH ____ DAY ____ YEAR	
B) CLAIM IS DENIED - DISABILITY LESS THAN 30 DAYS YES ☐ NO ☐	
C) CPP DISABILITY BENEFITS APPROVED YES ☐ NO ☐	
COMMENTS	

Date Received	Date Approved