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# CANADIAN CONSTRUCTION WORKERS' UNION (CCWU) BENEFIT TRUST FUND
# APPLICATION FOR SHORT TERM DISABILITY BENEFITS
## Policy 177869

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Member Health Management Services
1263 Wilson Avenue, Suite 302 | Toronto, Ontario | M3M 3G3
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: healthmanagement@bpagroup.com | ccwubenefits.ca

# Short Term Disability Benefits

If you become disabled while covered because of either an illness or accidental injury that is non-occupational and you cannot perform your job duties, you may be entitled to short term disability benefits

**What are the eligibility requirements?**

- You must be a member with plan coverage on the date your disability started.
- You must be actively at work on the date you become disabled - if you are laid-off, unemployed, or not working for any other reason you are not eligible for this benefit.

- Employer contributions must have provided your plan coverage on the day you become disabled - if your plan coverage was being maintained through self-payments at the onset of your disability, you are not eligible for this benefit.
- You must be under age 65 at the onset of the disability.

- Your disability must be a result of a non-occupational injury or illness - if the accidental injury or medical condition that prevents you from working was caused by work, you must file a claim with the Workplace Safety & Insurance Board (WSIB) - Health Management Services can assist you with your WSIB claim.
- If your disability was caused by or contributed by a motor vehicle accident which occurred in the province of Ontario or Quebec, this is a policy exclusion, and you are not eligible for this benefit.
- There are several other exclusions and limitations – please refer to the benefit plan booklet.

- You must be seen by, treated by, and be under the continued care of a licensed physician in Canada.
- You must be diagnosed with a bona-fide medical condition which prevents you from working and performing your pre-disability job duties.

- You must be absent from work for more than 7 days to receive this benefit (waiting period), unless
  - your disability was a result of a non-occupational accident - then the waiting period does not apply, or
  - you were hospitalized for at least 18 hours - then benefits start on the first day of hospitalization.

**How to apply for short term disability benefits?**

1. Ensure you meet the eligibility requirements for this benefit listed above
2. Complete and sign the **Member Statement** (Page 1) of the Application for Short Term Disability Benefits
3. Ensure your employer completes the **Employer Statement** (Page 2).
4. Ensure the physician overseeing your medical care completes the **Attending Physician Statement** (Page 3).
5. Obtain a Record of Employment (ROE) from your employer and apply for **Employment Insurance (EI) Sickness Benefits**.
6. All three (3) sections of the Application Package are required to begin assessing your claim.
7. Return the completed application to CCWU Care Health Management Services by


Email: **healthmanagement@bpagroup.com**


Mail: **1263 Wilson Avenue, Suite 302 | Toronto, Ontario | M3M 3G3**


Fax: **416-240-7047**


Questions: Email or call us at **416-240-2104** or **1-866-315-6011**

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# Short Term Disability Benefits

**How does short term disability work?**

- Once we receive your completed application, a Health Management Services representative will review your application to determine whether you meet the eligibility requirements for this benefit.
- If approved, short term disability benefits are payable at $500 per week, less tax withholdings.

- If you signed-up for direct deposit via eClaims, short term disability payment(s) will be automatically deposited into your bank account via electronic fund transfer. If you have not registered yet, you will receive payments via cheque. Refer to page 5 for instructions on how to register for eClaims and direct deposit.
- Physician fees incurred during the initial application process may be eligible for reimbursement up to a maximum of $100 if the claim is approved.
- Short term disability benefits are integrated with Employment Insurance (EI) sickness benefits - you are required to apply for this benefit.
- While EI benefits are payable, short term disability benefits are frozen. Should EI benefits end and your inability to work continues to be medically supported, short term disability benefit payments will be reinstated upon receipt of documentation supporting that EI benefits have ended.
- If you do not qualify for EI benefits, short term disability benefits payments will be issued during this period provided you submit supporting documentation of your ineligibility for EI benefits.

- During your disability from work, a Health Management Services case manager will work with you and your treatment providers to monitor your progress, ensure access to appropriate medical care, and coordinate plan benefits and services to promote your recovery and return to work.

- In order to remain eligible for short term disability benefits, you must
  - remain disabled from working and performing the essential duties of your pre-disability job,
  - remain under the continued care of a licensed physician in Canada,
  - be compliant with all aspects of your treatment plan including attending all recommended assessments, investigations, and treatments recommended by your physician and/or your treatment providers,
  - communicate regularly with your Member Health Management Services case manager and comply with any necessary requests required for the ongoing assessment and management of your claim, and
  - participate in modified return to work plans when available and suitable.

- Notify us immediately if
  - there is any change in your medical condition or in your ability or availability to work,
  - you return to work in any capacity or receive employment income, or
  - you intend to travel outside Canada.

- If you remain disabled and under appropriate care, short term disability benefits are payable until you
  - return to work,
  - are deemed fit to return to your pre-disability job,
  - attain age 65, or
  - reach the maximum benefit duration of 104 weeks of disability (inclusive of the EI period)

- If you return to work but sustain a subsequent disability, a new claim must be filed if you return to work
  - four weeks before becoming disabled due to the same or related cause or
  - one week before becoming disabled due to a different and unrelated cause.

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### How does long term disability work?

- If short term disability benefits end, you are under age 65, and you are totally disabled from working, you may be eligible for long term disability (LTD) benefits. Prior to the end of the short term disability period, Health Management Services will provide you an application for LTD benefits and assist you with the application process.

### Our Services

- Your health matters! At CCWU Care, we are always looking for new ways to service our members better. Member Health Management Services is your one-stop destination for support on all matters relating to disability, workers' compensation, health, and medical benefits and services to get you back to health.
- Our team is comprised of disability management specialist and health professionals trained to ensure members receive medical care focused on recovery and return to work. Member Health Management Services staff work with members in developing personalized plans and coordinating plan benefits and services on an expedited basis. If you or an eligible dependent is struggling with a health issue or in need of assistance accessing plan benefits and services, contact Member Health Management Services.

### Maintaining your benefit coverage while on disability

- Should your coverage terminate because you are unable to work due to disability, you have the option to continue your coverage by making self-payments to the members' benefit fund as follows:
  - Members on short term disability will be required to remit a monthly payment of $95 plus 8% RST, a total of $102.60.
  - You have the option to make self-payments for a maximum of 12 consecutive months provided you remain a Member in Good Standing with the Canadian Constructions Workers' Union.
  - Self-payments must be made within 31 days of the termination of your coverage and must be made on a continuous basis. Retroactive self-payments will not be accepted.
  - You will only be eligible to make a maximum of 3 self-payments at any given time and CCWU Trust Administration will not accept postdated cheques.
  - Your Union Dues with the Canadian Construction Workers' Union must be maintained and in a current status.
  - The Trustees may adjust the self-payment amount from time to time.
  - Self Pay cheques should be made payable to the "Canadian Construction Workers' Union Benefit Trust Fund."
- For more information refer to the benefit plan booklet, visit **ccwubenefits.ca**, or contact Member Services at **416-240-0047** or **info@ccwubenefits.ca.**

### Other Important Information

- Payment of monthly Union dues is your responsibility to remain in good standing.
- Depending on the nature of your condition, speak to your physician about Canada Pension Plan (CPP) disability benefits. CPP disability benefits will not affect your entitlement to short term disability benefits. If you have questions regarding the application process, Member Health Management Services can help.

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# Registering for Direct Deposit - Short Term Disability Benefits

**Already have EFT Direct Deposit set-up in eClaims?**

If you are eligible to receive short term disability benefit payments and have signed up for direct deposit via **eClaims**, payments will be automatically deposited directly into the authorized bank account via electronic fund transfer (EFT). An email will be sent to you confirming benefit payments have been made. In addition, you will have access to your short term disability claim history, explanation of benefits, and can submit documents securely through the **eClaims** app or website.

**Haven't Registered yet?**


Download the **BPA eClaims app** through the *App Store* or *Google Play* and follow the registration instructions. Make sure you have your Member Advantage benefit card handy as you will be asked to provide your *group number* (the first 6 digits of your card) and *certificate number* (the remaining 10 digits).

If you prefer to register online - go to **ccwubenefits.ca** and look for the **eClaims** link at the top, right-hand corner of your screen, click register account, and follow a few simple steps.

**Once I'm registered, what's next?**

Complete the attached **Application for EFT Direct Deposit** form in full and send it to us via

| | | |
|---|---|---|
| | Email at | **info@ccwubenefits.ca** |
| | Fax at | **416-240-7488** |
| | Questions | **416-240-0047** |

**What if I don't register for direct deposit?**

You will receive weekly short term disability benefit payments via cheque until you become registered.

# APPLICATION FOR EFT (CAD) DIRECT DEPOSIT

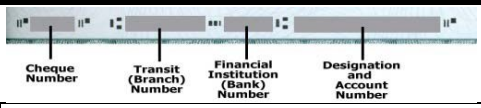
Send to: CCWUcare | 1263 Wilson Avenue, Suite 205 | Toronto, ON M3M 3G2
P: 416.240.0047 | F: 416.240.7488 | w: www.ccwucare.com | e: info@ccwucare.com

## A. Member Information *(Please Print)*

| | | |
|---|---|---|
| Last Name First Name | | Gender ☐ Male ☐ Female |
| Address | | Date of Birth (yyyy/mm/dd) |
| Town/ City Prov. Postal Code | | Country |
| Member Advantage Benefit Card ID Number (last 10 digits) | | *Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID)* |
| Email Address | | Phone # |
| Marital Status ☐ Married ☐ Commom-Law ☐ Single ☐ Separated ☐ Divorced ☐ Widow | | Cell # |

## B. Account Information

Account Holder Name(s):




| Transit No: | Bank No: | Account No: |
|---|---|---|

☐ New Authorization ☐ Change to Existing Authorization

## C. Authorization

I/We Acknowledge that this agreement is provided for the Benefit of the "Payee" and "Processing Institution" and is provided in consideration of the Processing Institution agreeing to process credits into the Account with the Processing Institution in accordance with the Rules of the Canadian Payments Association (the "CPA Rules").

By signing this agreement, I/We request my/our benefits to be paid through electronic funds transfer (direct deposit) into this account. This authorization may be cancelled at any time upon written notice by me/us. I/We warrant and guarantee that the Person(s) whose signature(s) is/are required to sign on the Account have signed the Agreement.

**Note: If only one signature is required for this account, then only one Payee is needed to sign. However, if two or more signatures are required, then both or all payees *must* sign.**

Payee Signature: _____ Payee (2) Signature: _____

Date: _____ Date: _____

Please complete, print, sign, and return by fax at 416.240.7488 **OR** email to info@ccwucare.com

# Application for Short Term Disability Benefits

Member Health Management Services | 1263 Wilson Avenue, Suite 302| Toronto, ON | M3M 3G3
Tel: 416-240-2104| Fax: 416-240-7047
Email: healthmanagement@bpagroup.com | ccwubenefits.ca

## 1. MEMBER STATEMENT

All three (3) sections of this application must be completed, signed, and submitted to initiate your claim for Short Term Disability benefits:

1. Member Statement
2. Employer Statement (or Record of Employment) completed by current employer
3. Attending Physician Statement completed by the Physician overseeing your care

If any section of this application is not completed or portions are not answered fully, the assessment of your claim may be delayed. You are required to apply for Employment Insurance (EI) Sickness Benefits as Short Term Disability benefits are not payable during the period payable by EI benefits.

## Member Information

| Last Name | First Name | | Union ID Number |
|---|---|---|---|
| Address | | | Date of Birth (mm/dd/yyyy) |
| Town/City | Province | Postal Code | Telephone Number |
| Email Address | | | Cell Phone Number |

## Absence Information

| Job Title | Last day worked (mm/dd/yyyy) | First day absent from work due to medical condition |
|---|---|---|
| Return to work date | Expected return to work date | Is your condition due to an accident? ☐ No ☐ Yes |
| Accident date | Is this due to a motor vehicle accident? ☐ No ☐ Yes | Is the accident or medical condition work-related? ☐ No ☐ Yes |

Describe the nature of your medical condition and/or how the accident occurred (time, location, activity being performed at time of injury)

Have you applied for or are you receiving any of the following Benefits?

| | | | |
|---|---|---|---|
| Employment Insurance (EI) Benefits | ☐ Applied | ☐ Approved | ☐ Denied |
| Workplace Safety & Insurance Board (WSIB) Benefits | ☐ Applied | ☐ Approved | ☐ Denied |
| Motor Vehicle Accident Insurance Benefits | ☐ Applied | ☐ Approved | ☐ Denied |
| Canada Pension Plan (CPP) Disability Benefits | ☐ Applied | ☐ Approved | ☐ Denied |
| Any other Disability or Income Continuation Benefits | ☐ Applied | ☐ Approved | ☐ Denied |

During your absence, will you be working or receiving income from another employer or self-employment?

☐ No ☐ Yes, Describe

## Member Declaration & Authorization for Release of Information

I certify that the information presented is true, correct, and complete. I understand that for the duration of this claim, I must immediately notify CCWUcare Health Management Services of my return to work in any capacity, my receipt of any employment income, and/or any change in my status as it relates to my ability to work or entitlement to short term disability benefits. CCWUcare is administered by Benefit Plan Administrators Limited (BPA) on behalf of the Canadian Construction Workers' Union (CCWU) Benefit Trust Fund. I hereby authorize BPA, administrators of the CCWU Benefit Trust Fund, and its subsidiaries, to collect, use, and exchange any and all information and documentation requested by BPA regarding or relating to my medical or mental health condition for the purpose of assessing and managing my claim for short term disability benefits and access to other benefits and services provided by the CCWUcare. This includes authorizing any physician, health care professional, hospital, public or private institution, my employer(s), and Union to provide to BPA any information required for the assessment or management of my claim for short term disability benefits. I authorize BPA to share with TeksMed Services Inc., third party provider, any and all information collected for the purpose of coordinating diagnostic scans and/or specialist consultations and/or procedure if placed on a medical wait list greater than 21 days, should I be eligible for this benefit. I authorize TeksMed Services Inc. to release the results of my diagnostic scan(s) and or specialist consultation(s) to BPA for the assessment and management of my claim for short term disability benefits. I authorize BPA to share with CAREpath, third party provider, any and all information collected for the purpose of providing me individualized nurse case management and health care navigation services should I be eligible for this benefit. I also authorize BPA to share with my Long Term Disability Insurer any and all information and documentation collected should I be eligible for Long Term Disability benefits. All personal information will be treated in a highly confidential manner. It is understood that this authorization is valid from the date hereof through my return to work. This authorization may be withdrawn at any time upon receipt of written notification to BPA. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original. By signing below, I consent to the collection, use, and disclosure of my personal information as stated above.

| Member Signature | Date |
|---|---|
| | |

# Application for Short Term Disability Benefits

Member Health Management Services | 1263 Wilson Avenue, Suite 302 | Toronto, ON | M3M 3G2
Tel: 416-240-2104| Fax: 416-240-7047
Email: healthmanagement@bpagroup.com | ccwubenefits.ca

## 2. EMPLOYER STATEMENT

CCWUcare Health Management Services is responsible for reviewing medical absences to assess eligibility to Short Term Disability benefits offered through the CCWU Benefit Trust Fund and coordinating other plan benefits and services to assist members in their recoveries and return to work. Please complete the following information in full and return directly to the member or send to CCWUcare Health Management Services via email at healthmanagement@bpagroup.com or fax at 416-240-7047. Please attach any additional information to help us understand the member's absence, work duties, or physical demands of the job.

### Member Information

| Member's Last Name | Member's First Name | Union ID Number |
|---|---|---|
| | | |

### Employment Information

| Job Title | Date of hire (mm/dd/yyyy) | Gross weekly earnings |
|---|---|---|
| | | |

Member's Normal Work Schedule:

| Day of Week | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Hours | | | | | | | |

Number of hours normally worked per week:

Provide a description of the Member's work duties or attach a job description or physical demands assessment

| Last day worked | First day absent from work | Actual or expected return to work Date |
|---|---|---|
| | | |

Reason for work absence

☐ Medical ☐ Lay-Off ☐ Dismissed ☐ Quit ☐ Leave ☐ Unknown ☐ Other

| Has the Member received pay after the last day worked? ☐ Yes ☐ No | If yes, provide final day paid |
|---|---|
| If lay-off, has member been recalled but unable to report due to medical reasons? ☐ Yes ☐ No | If yes, provide date of recall |
| Are modified duties available? ☐ Yes ☐ No | Are modified hours available? ☐ Yes ☐ No |

### Declaration

I certify that the above information is true, correct, and complete.

| Employer Contact Name | Title |
|---|---|
| Employer | Telephone |
| Employer Signature | Date |

Please complete and return this form to

**CCWUcare Health Management Services**
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## 3. ATTENDING PHYSICIAN STATEMENT

CCWUcare is responsible for reviewing medical absences to assess eligibility to Short Term Disability benefits offered through the CCWU Benefit Trust Fund and coordinating plan benefits and services to assist members in their recoveries and return to work. Please complete the following in full and return directly to your patient or send to CCWUcare via fax at 416-240-7047 or email at healthmanagement@bpagroup.com. Please attach any additional information regarding the nature or extent of the patient's condition or function. Any fees associated with the completion of this form is the responsibility of the patient.

### Patient Information

| Patient's Last Name | Patient's First Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

### Medical Information

| Date symptoms first appeared (mm/dd/yyyy) | Date of first visit after work absence | Date condition first prevented patient from working |
|---|---|---|
| | | |

| Is the condition a result of an accident? | Is the accident or condition work-related? | Is condition due to a motor vehicle accident? |
|---|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes | ☐ No ☐ Yes |

Primary Diagnosis

Secondary Diagnosis and/or Complications

Functional Abilities - current physical and cognitive abilities

| | | | | | |
|---|---|---|---|---|---|
| Hospitalization | ☐ No ☐ Yes | Admittance | Discharge | | |
| Surgery | ☐ No ☐ Yes | Surgery Type | Date | General Anesthesia | ☐ |
| Specialist | ☐ No ☐ Yes | Name/Type | Date | Pending | ☐ |
| Diagnostics | ☐ No ☐ Yes | Type | Date | Pending | ☐ |

**If currently on a wait list for specialist consult, diagnostic assessment, or procedure attach requisition so we may coordinate service on an expedited basis**

Treatment Plan - therapies, tests/investigations, referrals, specialty programs

Medications - name, dosage, and frequency

| Compliance ☐ Yes ☐ No, describe | Patient not competent to manage own affairs ☐ |
|---|---|

Prognosis & Return to Work goals - If patient fit to return to work with modifications, provide recommendations for return (restrictions, days per week, hours per day)

| Last assessment date | Next assessment date | Frequency of visits | Actual or estimated return to work date |
|---|---|---|---|
| | | | |

Please attach any additional information that would give us a better understanding of the patient's condition, treatment needs, and abilities

### Declaration

I certify that the above information is true, correct, and complete.

| Physician's Name | Tel Number |
|---|---|
| Physician's Address | Fax Number |
| Physician's Signature | Date |