CCWU care

BUILDING HEALTHY FUTURES

CCWU™

APPLICATION FOR LONG TERM CARE BENEFITS

Canadian Construction Workers' Union Benefit Trust Fund – CCWULTC2501

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: healthmanagement@bpagroup.com | ccwubenefits.ca

Long Term Care Benefits

If you or your eligible spouse become unable to perform certain activities of daily living due to physical or cognitive impairment or require substantial supervision to protect your health and safety while covered and require support at home or at a long term care facility, you or your eligible spouse may be entitled to Long Term Care Benefits.

What are the eligibility requirements?

- You or your eligible spouse must have plan coverage under the Canadian Construction Workers' Union Benefit Trust Fund on the date the need for long term care arose.
- You or your eligible spouse did not require long term care when your plan coverage started.
- You or your eligible spouse must be over the age of 18 when the need for long term care arose.
- You or your eligible spouse must be unable to perform at least two (2) of the six (6) listed ***activities of daily living*** without assistance due to a loss in functional capacity or you or your eligible spouse require ***substantial supervision*** to protect health and safety due to cognitive impairment.
- You or your eligible spouse must be in need of long term care for a period greater than 90 days to receive this benefit (waiting period).
- Care or treatment must be provided in Canada or the United States.
- A surviving spouse of an active member is eligible for a period of up to two (2) years from the member's date of passing while in benefit.

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 **Claimant Statement** (Section 1) of the Long Term Care Application Form.

   An authorized representative may complete this form if you are unable to do so.
3. Complete all authorization forms and attach copies of any Power of Attorney documents, if applicable.
4. Ensure the physician(s) overseeing your medical care completes the **Physician Statement** (Section 2).
5. The **Claimant** and **Physician Statements** are required to begin assessing your claim.
6. Return the completed application to CCWUcare Health Management Services by

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

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Long Term Care Benefits

What are the Activities of Daily Living?

- (1) **Bathing** – washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- (2) **Continence** – the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- (3) **Dressing** – putting on and taking off all necessary items of clothing and any necessary braces, fasteners or artificial limbs.
- (4) **Eating** – feeding oneself by getting food, already prepared and made available, into the body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
- (5) **Toileting** – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (6) **Transferring** – moving into or out of a bed, chair or wheelchair with or without the use of equipment.
- **Substantial Supervision** – continual supervision which may include cueing by verbal prompting, gestures or other demonstrations, by another person to protect the applicant from threats to health and safety.

What does the Long Term Care Benefit Cover?

If you or your eligible spouse meet the eligibility requirements, you may be eligible for the following benefits:

- A maximum **Daily Indemnity Benefit** of up to $50 per day if you qualify as needing long term care.
- A maximum **Additional Daily Reimbursement Benefit** of up to $100 per day towards the actual incurred costs of **home care** or **home health care** services provided by a licenced agency, **hospice care**, and **long-term care facility**.
  - **home care services provided by a licensed agency** for the purpose of providing assistance with the activities of daily living and to allow you or your eligible spouse to remain safely at home,
  - **home health care services provided by a licensed agency** for medically necessary services such as nursing, physical therapy, and occupational therapy, provided in the member or eligible spouse's home.
- A maximum **Respite Care Benefit** of up to $100 per day if receiving the Daily Indemnity Benefit for a maximum of 21 days in each 12-month period following the date of the claim for actual costs incurred for additional home care or home health care services provided by a licenced agency when the insured person's primary unpaid caregiver requires relief from providing such care. Unused portions of this benefit cannot be carried forward.
- A maximum **Home Modification Reimbursement Benefit** of up to $1,000 per period of care for the actual incurred costs for the installation of safety equipment such as safety handrails, grab bars and ramps provided that the costs are incurred within 60 days of the date of eligibility.
- A maximum **Grief Counselling Reimbursement Benefit** of up to $2,000 per period of care for the actual costs of incurred within 365 days of the death of the insured person, for grief counselling for the surviving spouse, caregiver and/or dependent children.
- The **lifetime maximum benefit is $300,000 per person**.

There are certain exclusions and limitations – please refer to the benefit plan booklet for greater detail.

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1. CLAIMANT STATEMENT

All sections of this application must be completed, signed, and submitted to initiate your claim for long term care benefits. If any section of this application is not completed or portions are not answered fully, the assessment of your claim may be delayed. An authorized representative may complete this form if the member or eligible spouse is unable to do so. Attach copies of all Power of Attorney documents, if applicable. Please return to completed application to CCWUcare Member Health Management Services.

MEMBER & CLAIMANT INFORMATION

Member's Name		Union ID Number
Claimant - Person Requiring Long Term Care ☐ Member ☐ Member's Spouse	Claimant's Name (Name of Member or Spouse Requiring Long Term Care)	
Claimant Date of Birth (mm/dd/yyyy)	Primary Telephone Number	Alternate Telephone Number
Address		
Is the Claimant currently residing at the address listed above? ☐ Yes ☐ No		
With whom does Claimant live? ☐ Alone ☐ Spouse ☐ Relative / Other ☐ Facility		
If Claimant is not residing at the address at the top of this page: Where is the insured currently residing?		
Facility Name or Relative / Other Name and Relationship		Telephone Number
Address		Email Address

AUTHORIZED CONTACT INFORMATION

Name of Authorized Contact filing claim		Relationship to Claimant
Telephone Number	Email Address	Are you the primary contact for questions regarding this claim? ☐ Yes ☐ No
Alternative Authorized Contact person		Relationship to Claimant
Telephone Number	Email Address	Are you the primary contact for questions regarding this claim? ☐ Yes ☐ No

POWER OF ATTORNEY (POA) or LEGAL GUARDIAN

Does Claimant have a Power of Attorney (POA) or Legal Guardian? ☐ Yes ☐ No	POA / Legal Guardian Name	
Relationship to Claimant or Title	Telephone Number	Email Address
Address		Fax Number

A COPY OF POWER OF ATTORNEY DOCUMENTS MUST BE SUBMITTED WITH THIS FORM

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Claimant Name	Union ID	Date of Birth

CLAIM INFORMATION

What is the cause, condition or physical dependency that required the Claimant to seek long term care services?

What is the date the Claimant first sought treatment for this condition?

Are the following expenses being incurred:

☐ Long Term Care Facility or Hospice ☐ Home Health Care ☐ Home Care ☐ Other (Please describe)

Please attach Explanation of Benefits from your other insurer for any services you are also claiming under this Long Term Care Plan.

ACTIVITIES OF DAILY LIVING & SUPERVISION

Please check all Activities of Daily Living for which the Claimant requires assistance and provide details:

Activity	Who provides assistance?	Describe the type of assistance provided:
☐ Bathing		
☐ Continence		
☐ Dressing		
☐ Eating		
☐ Toileting		
☐ Transferring		
☐ Substantial Supervision		

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Claimant Name	Union ID	Date of Birth

CAREGIVER INFORMATION

List all caregivers who currently provide support (include licensed caregivers as well as friends and family members who have been providing assistance). Copy this page to submit additional caregivers or continue on a separate sheet if needed.

1. Agency/Person Name		Relationship to Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

2. Agency/Person Name		Relationship to Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

3. Agency/Person Name		Relationship to Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

4. Agency/Person Name		Relationship to Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

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Claimant Name	Union ID	Date of Birth

PRIMARY PHYSICIANS

List all physicians consulted for condition and Primary Care Physician(s) consulted in the **past 5 years**. Copy this page to submit additional physicians or continue on a separate sheet if needed.

1. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

2. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

3. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

HOSPITALIZATIONS / NURSING FACILITY CONFINEMENTS

Please provide details for all hospitalizations/nursing facility confinements in the **1 past year**. Copy this page to submit additional hospitalizations or continue on a separate sheet if needed.

1. Facility Name		
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)	Telephone Number
Address		Fax Number

2. Facility Name		
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)	Telephone Number
Address		Fax Number

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Claimant Name	Union ID	Date of Birth

CLAIMANT (OR POWER OF ATTORNEY) DECLARTION

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 Member Health Management Services and LifePlans LTC Services Inc. of any change in the claimant's status as it relates to their entitlement to long term care benefits.

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

CCWUcare is administered by Benefit Plan Administrators Ltd (BPA) on behalf of the Canadian Construction Workers' Union Benefit Trust Fund (Benefit Trust Fund). LifePlans LTC Services Inc., a third-party provider, has been appointed by CCWUcare to review and assess this claim to determine entitlement to long term care benefits under the Benefit Trust Fund. As an eligible member or eligible spouse of the Benefit Trust Fund, I hereby consent to CCWUcare and LifePlans LTC Services Inc.'s collection, use, and disclosure of my personal information for purposes related to determining my eligibility and entitlement to long term care benefits under the Benefit Trust Funds. I hereby authorize the following uses and disclosures of health information about me:

1. The health information that I am authorizing to be used or disclosed consists of all of the following information:

My medical records and medical history; and other information that relates to:

• The diagnosis of any physical or mental condition,

• The treatment or prognosis of any physical or mental condition,

Whether such treatment is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug use; and communicable or infectious conditions.

2. The following persons or entities are authorized to disclose health information about me to CCWUcare and LifePlans LTC Services Inc. and their service providers, agents, and representatives.: A doctor; medical practitioner; hospital; clinic or medical or medically related facility; pharmacy or pharmacy benefit manager; or any other organization, institution, or person having health information about me.

3. Health information about me may be exchanged between CCWUCare and LifePlans LTC Services Inc.

4. Health information about me may be used or disclosed to evaluate or process any claim for long term care benefits or to service my long term care benefit coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. CCWUcare and LifePlans LTC Services Inc. are authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want CCWUCare and LifePlans LTC Services Inc. to discuss your claim.)

Print Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Relationship: _____ Phone: _____

6. I understand that:

• If I do not sign this Authorization, CCWUCare may decline to pay any claim for long-term care benefits.

• I may withdraw this authorization at any time by providing written notice to CCWUCare. Although an authorization may generally be revoked by sending a written request to CCWUCare, there is no right to revoke this Authorization if my claim for benefits may be contested by CCWUCare or if CCWUCare has already relied and acted upon this Authorization.

• A copy of this Authorization is as valid as the original.

• I may request a copy of this Authorization.

CCWUCare is committed to protecting and maintaining the confidentiality of all personal information collected. All information will be handled in accordance with applicable privacy laws and CCWUCare 's internal data protection policies, ensuring secure handling and storage.

By signing below, I consent to the collection, use, and disclosure of my personal information as outlined above.

Claimant or Power of Attorney (POA) - If this authorization is signed by a POA, a copy of the POA must be included.

Claimant or Power of Attorney (POA) Signature	Date

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2. PHYSICIAN STATEMENT

Claimant: Please provide this form to the physician most familiar with your current condition for completion. Your assistance will expedite the claim process as you or your Power of Attorney will be able to sign any required medical release authorizations. If multiple physicians are involved in your care, you may copy this document as needed to assure all pertinent information is obtained. **Physician:** Please complete all information requested on this form. The purpose of this document is to provide basic medical information for a long term care benefit claim about the claimant and assist the claims examiner to assess your patient's eligibility for long term care benefits. Please complete this form and return to the patient or email to healthmanagement@bpagroup.com or fax to 416-240-7047. Any fees associated with the completion of this form is the responsibility of the applicant.

CLAIMANT NAME	UNION ID	DATE OF BIRTH

MEDICAL INFORMATION (to be completed by Physician)

Patient's Name	Date of Birth (mm/dd/yyyy)

What is the primary condition(s) causing the loss: Please list all diagnoses that have resulted in the need for long term care:

Primary Diagnoses	Date of Onset (mm/dd/yyyy)

Secondary Diagnoses	Date of Onset (mm/dd/yyyy)

Is there a diagnosis of cognitive impairment? ☐ Yes ☐ No	If yes, please provide a specific diagnosis
Date of Cognitive Test (mm/dd/yyyy)	Cognitive Testing Results (Please attach test documents and results)
Last time you saw the patient?	What was the nature of the visit? (primary complaint)

Please attach all pertinent medical records that will allow us to evaluate the cause, condition, or physical dependency that required the patient to seek long term care services.

DECLARATION

I certify that the information above is accurate and complete to the best of my knowledge:

Physician's Name and Specialty	Telephone Number
Address	Fax Number
Physician's Signature	Date