



Failure to provide all information requested may delay this claim. You must submit this claim to BC Life within the policy claiming deadline.

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1 Telephone 604 419-8040 Fax 604 419-8055

Employee's Statement (Please type or print in ink)

Name Sex F M Social insurance number Date of birth Mo Day Yr Job title Number of years in this job Address Box no. (if applicable) City Province Postal Code Phone number Date you became unable to work Mo Day Yr Date first able to return to work Mo Day Yr Date you first saw a doctor after you stopped working Mo Day Yr Name and phone number of physician(s) Are you entitled to receive any income from other income replacement plans or sources? Yes No If yes, amount of other income \$ Name of company

Accident Information (complete shaded section only if claim is the result of an accident)

Date of accident Mo Day Yr Time of accident A.M. P.M. Where did accident happen? Work Home Elsewhere (specify) Describe how the accident happened

Signature/Authorization

I, the undersigned, hereby make claim for short term disability benefits. I certify that the above facts are true and complete and authorize the release to British Columbia Life & Casualty Company (BC Life) all medical reports and other information requested to assess my claim.

Signature of employee Date signed Mo Day Yr

Employer's Statement

Name of employee Date of hire Mo Day Yr Identity number Employer name Policy number If the administration type is self-reporting provide: Effective date of STD coverage Mo Day Yr LTD coverage Mo Day Yr Has coverage been cancelled? Yes No If yes, give date Mo Day Yr Reason Date last worked Mo Day Yr On date last worked: a) employee class b) basic earnings \$ per As of today, has this employee returned to work? Yes No If yes, provide date returned to work Mo Day Yr Is absence due to an occupational injury or illness? Yes No Has claim been filed with the Worker's Compensation Board Yes No If yes, date filed Mo Day Yr Status Employee's job duties If the employee has holidays scheduled, or is on any type of leave during this absence, please complete the following: Leave of absence Paid sick leave Holidays Bereavement Maternity Give dates Mo Day Yr TO Mo Day Yr Please include any other information which may help BC Life assess this claim This certifies that according to our records, the employee was covered under our plan when this absence commenced. Signature of authorized official Title Date signed Mo Day Yr

Attending Physician's Statement - Accurate assessment of this claim depends on each question being answered in full.

Name of patient _____ Date of birth

Mo	Day	Yr

Diagnosis of present condition
 Primary _____
 Secondary _____

If patient is pregnant, give expected date of delivery

Mo	Day	Yr

 If condition is due to an accident, give date accident occurred

Mo	Day	Yr

If reported to W.C.B. or related to patient's occupation, provide details _____

Subjective complaints, including date of onset, severity and frequency _____

Date you first treated patient for this condition

Mo	Day	Yr

 Date you recommended your patient stop work

Mo	Day	Yr

Date of most recent treatment

Mo	Day	Yr

 Were diagnostic studies made? Yes No Date(s) of studies

Mo	Day	Yr

Type of studies and findings (please include copies of results) _____

If you have referred patient to a specialist, give name(s) of physician, speciality and appointment date _____

If patient was referred to you, give name of referring physician _____

If hospitalized, name of hospital _____ Dates confined to hospital

Mo	Day	Yr

 TO

Mo	Day	Yr

What surgery if any was performed? _____ Date of surgery

Mo	Day	Yr

Treatment (e.g. medication & dosage, physiotherapy, psychotherapy, etc.) and frequency _____

Check dates of visits exclusive of above procedures

Place	Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
Office																																			
Hospital																																			

Restrictions (what patient should not do) _____

Limitations (what patient can not do) _____

If appropriate treatment is followed, do you expect your patient to return to pre-illness/injury functioning? Yes No

If yes, provide date

Mo	Day	Yr

 OR from today, the estimated number of weeks before recovery _____

If no, please explain _____

Name of physician (print) _____ MSC number _____

Address _____ Phone _____ Fax _____

Specialty _____ Signature _____ Date signed

Mo	Day	Yr

Authorization of Patient

I authorize the release to British Columbia Life & Casualty Company (BC Life), all medical reports and other information requested to assess my claim.

Signature of patient _____ Date signed

Mo	Day	Yr

The patient is responsible for any charges made for completion of this form.