BPA

Health Management Services

INSULATORS LOCAL 95 TRUST FUND

WEEKLY INCOME REPLACEMENT BENEFITS

Health Management Services
90 Burnhamthorpe Road West, Suite 300 | Mississauga, Ontario | L5B 3C3
Tel: (905) 275-6466 | Toll Free: 1-800-867-5615| Fax: (905) 275-6462
Email: healthmanagement@bpagroup.com | Web: insulators95benefits.ca

INSULATORS LOCAL 95 BENEFIT FUND
WEEKLY INCOME REPLACEMENT BENEFITS

How to apply for Weekly Income Replacement Benefits?

1. Confirm your benefit plan coverage at the onset of your disability
2. Ensure you meet the eligibility requirements for this benefit listed below
3. Complete all 3 sections of the enclosed **Weekly Income Replacement Benefit Application form**
   i. **Member Statement** section (page 1) to be completed by the member
   ii. **Employer Statement** (page 2) to be completed by your current employer
   iii. **Attending Physician Statement** (page 3) to be completed by the physician overseeing your care
4. Obtain a Record of Employment (ROE) from your employer and apply for **Employment Insurance Sick Benefits**
5. Return all portions of the Weekly Income Replacement Benefits Application form to Benefit Plan Administrators Ltd (BPA) Health Management Services via

   Email: healthmanagement@bpagroup.com

   Fax: (905) 275-6462

   Mail: 90 Burnhamthorpe Road West, Suite 300 | Mississauga, ON | L5B 3C3

6. Submit the Application at the same time you apply for Employment Insurance Sick Benefits
7. All three (3) sections of the Application form are required to begin assessing your clam.

What are the eligibility Requirements?

- You must be an eligible active member with benefit 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 and have been recalled to work, but unable to return due to disability, you may be eligible for this benefit
- Employer contributions must have provided your benefit plan coverage on the day you become disabled (if your benefit coverage is being maintained through self-payments, you are not eligible for this benefit)
- You must be under age 70 at the onset of your disability
- Your disability must be a result of a non-occupational illness or non-occupational injury
- If your disability was caused by or contributed by a motor vehicle accident which occurred in the provinces of Ontario or Quebec, this is excluded, and you are not eligible for this benefit
- There are several other exclusions and limitations – please refer to the plan booklet or insulators95benefits.ca
- You must be diagnosed with a bona-fide medical condition which prevents you from working and performing the essential duties of your own pre-disability occupation
- You must be seen by, treated by, and under the continued care of a licensed physician (M.D.) in Canada
- You must be absent from work for more than one (1) week (qualifying period).

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How does Weekly Income Replacement work?

- Once we receive your completed application, a BPA Health Management Services representative will review your application to determine whether you meet the eligibility requirements for this benefit
- If approved, weekly income replacement (WI) benefits are payable at $573 per week less tax withholdings
- Benefits are integrated with Employment Insurance (EI) Sickness benefits and you are required to apply for EI
  - While EI benefits are payable, WI benefits are not payable
  - If you do not qualify for EI benefits, WI benefits may be issued during this period provided you submit supporting documentation of your ineligibility for EI benefits
- If approved, WI benefit payments will commence after EI benefits end, provided you remain disabled
- WI benefits are reduced by the amount of Canada Pension Plan (CPP) Disability / Quebec Pension Plan (QPP) Disability benefits which are payable to you from the 27th week of disability – **it is your responsibility to promptly apply for CPP/QPP benefits and advise BPA of the status of your application. Failure to do so will result in the suspension of WI benefit payments**
- Benefits are also reduced by any other income payable under any other plan or program provided to you by your employer, government, or any subdivision or agency of the government
- 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 until you are fit to return to work
- In order to remain eligible for WI 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 treatment recommended by your physician and/or your treatment providers,
  - communicate regularly with your Health Management Services case manager and comply with any necessary requests required for the ongoing assessment and/or management of your claim,
  - participate in modified return to work plans when available and suitable, and
  - immediately notify us of your return to work in any capacity, any change in your work status or availability to work, if you intend to travel outside Canada, or if there is any change in your medical status
- WI Benefits are payable until you
  - return to active full-time work,
  - are deemed fit to return to your pre-disability job,
  - retire or turn age 70, or
  - reach the maximum benefit duration of 104 weeks of disability (inclusive of the EI period)
- If you return to work but sustain a successive disability, a new claim must be filed if you return to work:
  - Two (2) weeks before you again become disabled because the same or related cause;
  - One (1) day before you again become disabled because of a different or unrelated cause.

How does long term disability work?

- If WI ends, you are under age 60, and you remain totally disabled, you may be eligible for long term disability (LTD) benefits offered through the benefit plan. Prior to the end of WI benefit period, Health Management Services will assist you with your application for LTD benefits.

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Application for Weekly Income Replacement Benefits

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MEMBER STATEMENT

All three (3) sections of this application must be completed, signed, and submitted to initiate your claim for Weekly Income Replacement Benefits:

1. Member Statement
2. Employer Statement (or Record of Employment) completed by your current employer
3. Attending Physician Statement completed by the Licensed Medical Doctor 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 Weekly Income Replacement benefits are not payable during the EI benefit period.

Member Information

Last Name	First Name		Member 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) 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 BPA Health Management Services of my return to work in any capacity, my receipt of any employment income, and any change in my status as it relates to my ability to work or entitlement to Weekly Income Replacement benefits. I hereby authorize Benefit Plan Administrators Ltd (BPA), administrators of the Insulators Local 95 Benefit 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 Weekly Income Replacement benefits and access to other benefits and services provided by the Insulators Local 95 Benefit Fund. 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 Weekly Income Replacement 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 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 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

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EMPLOYER STATEMENT

BPA Health Management Services is responsible for reviewing medical absences to assess eligibility to benefits offered through the Insulators Local 95 Benefit Fund and coordinating benefits and services to assist Members in their recoveries and return to work. The information below is required to assess the Member's ability to work and eligibility to Weekly Income Replacement benefits offered through the Benefit Plan.

Please complete the following information in full and return directly to the Member or send to BPA Health Management Services. 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 ☐ Retired ☐ Unknown

If Lay-off, Please Provide Date of Lay-Off:

Has the Member Received Pay After the Last Day Work?	If Yes, Provide Date Pay Stopped
☐ Yes ☐ No	
Was the Member Recalled back to Work but Unable due to Medical Reasons?	**If Yes, Provide Recall Date**
☐ Yes ☐ No	
Are Modified Duties Available?	**Are Modified Hours Available?**
☐ Yes ☐ No	☐ 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
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ATTENDING PHYSICIAN STATEMENT

BPA Health Management Services is responsible for reviewing medical absences to assess eligibility to Weekly Income Replacement benefits offered through the Local 95 Benefit Plan. Please complete the following information in full and return directly to your patient or send to BPA Health Management Services via fax or email. Please attach any additional information that would help us understand the nature or extent of the patient's medical status or absence from work. 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 or a diagnostic assessment 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)

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	Telephone Number
Physician's Address	**Fax Number**
Physician's Signature	**Date**