ATTENDING PHYSICIAN'S STATEMENT

PART 1: PATIENT AUTHORIZATION ***(to be completed by patient, please print)***

Patient's Name:

Date of Birth: Day Month Year

I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim.

Patient's signature: Date:

PART 2: ATTENDING PHYSICIAN'S STATEMENT ***(to be completed by physician, please print)***

1. Diagnosis of present condition
   a) Primary
   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened *(day, month, year)*
   b) has patient had same or similar condition: [ ] No [ ] Yes
   If yes, please state when and describe

3. Is condition due to injury or sickness arising out of patent's employment? [ ] Yes [ ] No [ ] Unknown

4. If patient is/was pregnant indicate date or expected date of confinement: *(day, month, year)*

5. Date of hospital in-patient admission *(day, month, year)*
   Date of discharge *(day, month, year)*

6. Nature of treatment *(e.g. date and type of surgery)*

7. a) If patient was referred to you, give name of referring physician.
   b) If you have referred patient to a specialist, give name(s) of physician.

8. a) Date of first visit during present period of absence from work. *(day, month, year)*
   b) Date of latest attendance. *(day, month, year)*
   c) Were you actively supervising this patient's care during the full period
   [ ] No, comment in remarks
   [ ] Yes, state frequency of visits: [ ] Weekly [ ] Monthly [ ] Other *(specify)*

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition.
   From: *(day, month, year)* To: *(day, month, year)*
   b) If still unable to work, give approximate date patient should be able to return *(day, month, year)* or, the estimated number of weeks before possible return

10. Please advise how present condition affects patient's ability to work *(i.e., restrictions, limitations, proposed surgery, etc.)*

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician *(please print)* | Specialty | Telephone no. ( )

Address *(number, street, city, province postal code)*

Signature | Date *(day, month, year)*

MANION WILKINS & ASSOCIATES LTD.
626-21 Four Seasons Place
ETOBICOKE, ON M9B 0A5
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The patient is responsible for securing this form and for charges made for its completion
Please return completed form to your patient

DRYWALL, ACOUSTIC, LATHING AND INSULATION LOCAL 675 HEALTH BENEFIT TRUST FUND

Weekly Disability Income - Statement of Claim

SECTION 1 - TO BE COMPLETED BY THE MEMBER ***(please print)***

MEMBER'S NAME (Last)	(First)	
ADDRESS (Number, Street, City, Province)		POSTAL CODE
PHONE NUMBER ( )	DATE OF BIRTH Day / Month / Year	SOCIAL INSURANCE NUMBER	GROUP INSURANCE POLICY # **410001**

1. On what date were you first disabled and unable to work? Day / Month / Year ____ Time ____ a.m. / p.m.
2. On what date do you expect to return to work? Day / Month / Year ____
3. Is disability due to an accident? [ ] NO [ ] YES
   If "YES" please answer the following questions:
   a) When did it happen? Day / Month / Year ____ Time ____ a.m. / p.m.
   b) Where did it happen? [ ] at home [ ] at work
   [ ] elsewhere (name place) _____
   c) How did it happen? _____
4. On what date were you first treated by a physician for this disability? Day / Month / Year ____
5. List names and addresses of physicians who have treated you in connection with this disability.

   _____ _____

   _____ _____
6. Have you been hospitalized in connection with this disability? [ ] NO [ ] YES If "YES" please indicate:
   Name of hospital: _____
   Dates hospitalized: FROM Day / Month / Year ____ TO Day / Month / Year ____
7. Are disability benefits payable from any other source as the result of this sickness or injury? [ ] NO [ ] YES
   If "YES" give name of source: _____
8. I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that Manion, Wilkins & Associates Ltd. will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize Manion, Wilkins & Associates Ltd. to evaluate or investigate my claim, and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my employer, any licensed physicians or other health professionals, any medical facility, any insurance company or government body, and any other person or institution to release relevant information to Manion, Wilkins & Associates Ltd. solely for the purpose of processing this claim. I hereby authorize Manion, Wilkins & Associates Ltd. to allow my Local 675 Sr. Business Representative to view my physician's statement as part of the certification process. A photocopy of this release shall be as valid as the original.

_____ _____

Employee's Signature Date

SECTION 2 - TO BE COMPLETED BY A UNION REPRESENTATIVE ***(please print)***

1. On what date did the employee last work? Day / Month / Year ____ Number of hours: ____
2. What was the reason for leaving work? Check appropriate box:
   [ ] Disability [ ] Dismissed [ ] Temporary Layoff [ ] Strike [ ] Quit [ ] Retired
3. If employee became disabled while on Layoff, what was the date he/she was recalled and was unable to report to work? Day / Month / Year ____
4. Is this disability due to an occupational sickness or injury? [ ] NO [ ] YES
   If "YES" has a claim been made for Workplace Safety Insurance Board benefits? [ ] NO [ ] YES

Member Name: _____ Union No: _____
Please Print

Signed by: _____ Title: _____ Date: _____

ONCE COMPLETED, PLEASE FORWARD TO THE OFFICE OF THE ADMINISTRATOR AS INDICATED BELOW

Trust Fund Office: Manion Wilkins & Associates Ltd., 626-21 Four Seasons Place, Etobicoke, Ontario M9B 0A6 Telephone: (416) 234-5044
(800) 263-5621