MOTION PICTURE WORKERS
HEALTH BENEFITS TRUST
c/o IATSE LOCAL 891

PROCEDURES TO CLAIM SHORT TERM DISABILITY BENEFITS

The **Short Term Disability** (STD) benefits help you through periods when you are off work due to disability caused by illness or accidental injury outside of the workplace.

To qualify for STD, a member must have an active hourbank at the time of their date of disability or illness. Benefits are not payable for any period of disability if you are covered by full (140 hour) self-payment for the month in which you become disabled unless you have at least 140 current employer hours earned but not yet posted to the hourbank or you are able to demonstrate to the reasonable satisfaction to the Trustees that employment in the bargaining unit covered by IATSE Local 891 is a primary source of income. (Contact the 891 Health Benefits Representative if you are unsure that you qualify.) Benefits will be paid up to a maximum of 40 weeks for any one period during which you are totally disabled and prevented from performing work of any kind for a participating employer.

Benefits will commence on the 1st day of disability resulting from an accident (if you see a doctor on that day), on the 1st day of hospitalization or on the 8th day of disability resulting from illness not requiring hospitalization (if you see a doctor by the 8th day). You must have coverage on the 1st day of disability in order to receive benefits. Benefits are paid pro-rata on the basis of a 7 day work week. Please note that the STD benefit is a taxable benefit.

What you need to do ☑:

- ☐ Contact your medical doctor immediately upon becoming disabled.
- ☐ Obtain a Short Term Disability claim form and EFT (Direct deposit form if you want this option) from the Union Office or the Plan Office.
- ☐ Complete the front of the claim form and sign it.
- ☐ Ask your medical doctor to complete the Physician's Statement on the back of the same form. Please note: as per policy outlined in the benefit booklet, "Any cost for completion of medical reports will be your responsibility."

  Benefit entitlement may also be paid for a period of up to six weeks for any one disability on the signature of a chiropractor. For benefits beyond these six weeks, the signature of a medical doctor will be required.

  Benefits can also be paid for a period of up to two weeks if disabled after the removal of wisdom teeth on the signature of a dentist. For benefits beyond these two weeks, the signature of a medical doctor will be required.

- ☐ **Submit the STD application form to Homewood Health Inc. (HHI). They will manage the short term disability.**

  Complete and submit the EFT (direct deposit form) to HHI

- ➞ HHI may ask you for additional information before approving the claim. If you are unsure what is needed or how to get it, ask your Union Office or the Plan Office for help.
- ➞ Claims should be submitted within 60 days of start of disability unless special circumstances prevent you from doing so.
- ➞ Claims submitted more than 60 days after start of disability will require approval from the Health Benefits Trustees, which will delay STD payments if approved. Please include a written explanation for late filing attached to your claim.

➞ Benefits will be paid only while a member remains under the full-time care of a physician and/or surgeon. Be sure to continue seeing your doctor and follow treatment instructions while you are disabled. Keep your doctor up-to-date on any other counseling or treatment you are receiving. This way, your doctor can include it in their reports.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party (e.g. ICBC) is liable only when a person undertakes to endeavor to collect at least the amount of benefits paid and refund amount paid to the Trust. The third party reimbursement agreement, sent to you from HHI, must be completed before HHI advises to pay any benefits.

Occupational Disability (Work-Related)

- ☐ Report to the first aid attendant immediately upon becoming injured. If there is no first aid attendant, report to your supervisor, foreman or someone else in charge.
- ☐ Report to the employer (IATSE is not the employer). Ask them to fill out the Form 7 for WSBCB.
- ☐ Seek medical assistance ether at emergency or your GP immediately upon becoming injured and ensure to advise your treating physician that it is, or may be a work-related injury.
- ☐ Obtain a Form 6 from WSBC or the Union Office. Fill it in promptly and accurately and return it to WSBC via mail or fax. You may also report the claim over the phone by calling 1-888-workers (1-888-967-5377).
- ☐ Obtain a STD claim form from the Union Office or the Plan Office.
- ☐ Obtain a WCB Reimbursement Agreement from the Union Office or the Plan Office.
- ☐ Complete the front of the STD claim form and sign it.
- ☐ Ask your medical doctor to complete the Physician's Statement on the back of the same form. *Please note: as per policy outlined in the benefit booklet, "Any cost for completion of medical reports will be your responsibility."* Benefit entitlement may also be paid for a period of up to six weeks for any one disability on the signature of a chiropractor. For benefits beyond these six weeks, the signature of a medical doctor will be required.
- ☐ Complete the WCB Reimbursement Agreement.
- ☐ Submit to HHI: the STD claim form, the WCB Reimbursement Agreement **AND** a copy of the decision letter (if received) for approval.

Hours will be credited to your bank if you are disabled and in receipt of Disability Benefits from HHI, ICBC wage loss, WCB wage loss or EI sickness benefits. You must provide cheque stubs or other documentation to the union office for verification of what period you were on ICBC, WCB or EI Sickness.

Claims will be assessed by HHI and once approved, you will receive your benefit cheques by Mail or direct deposit if you have chosen this option.

Dues

IATSE Local 891 has established a medical leave policy which addresses the dues and arrears circumstances of members who are unable to work due to illness or injury. While on medical leave, members qualify for temporary dues payments of $50 per quarter. Obtain a Medical Leave form & policy from the Union Office.

Questions? Please contact your Health Benefits Rep @ the Union Office: 604.664.8914 or healthbenefits@iatse.com

SHORT TERM DISABILITY APPLICATION FORM

Dear Member:

In order to be eligible for Short Term Disability benefits, you must have an active hour bank at the time of disability. Additionally, you may not qualify if you self-paid the full amount towards the month you became disabled – however, please check this with IATSE local 891.

In order for you to apply for STD benefits, medical information is required from your physician. In order for your physician and any care givers involved in your recovery to share information with Homewood Health Inc. (HHI) care managers, please sign the release of information form provided below. Your medical information is kept in the strictest of confidence by HHI care managers. The only information requested from caregivers involved in your care, is medical information relevant to the current condition that prevents you from being at work. HHI care managers do not share any medical information with your employer or union representatives unless you have provided expressed written consent. The only information HHI care managers provide to your employer is information regarding your fitness for work and ability to return to work in some capacity.

NOTE TO MEMBER: In order to receive income continuance benefits, you must submit an application for STD benefits, to do so please:

1. When you receive this form please make sure that IATSE knows of your absence.
2. Sign the Authorization to Release Medical Information.
3. Have your doctor complete the Physician section in detail; you are responsible for any costs associated with the completion of this form.
4. You are responsible to urgently fax or have your physician fax, the fully completed and signed form (2 pages) directly to HHI at **1-888-429-1747**. HHI will review your claim and advise you by phone and in writing, and the Health Benefit Rep at the IATSE local 891 office of the outcome. Your application for STD must be received by HHI within 60 days of the injury/illness. Failure to submit within the time frame may result in delay or in the application being denied.

MEMBER'S APPLICATION & AUTHORIZATION FOR RELEASE OF INFORMATION SIGNATURE

I hereby authorize Homewood Health Inc. (HHI) to consent, use and disclose all information and documents pertaining to my Short Term Disability (STD) case with any physicians, therapists and other health care providers for the purpose of determining my eligibility for benefits and managing my medically supported absence.

I also authorize HHI to collect, use and disclose information about me within the HHI organization and with any physicians, treatment providers, service providers or medical and para-medical professionals for the purpose of facilitating optimal care and for planning and managing my return to work.

I also authorize HHI to provide all related medical information to the insurance carrier should I need to apply for Long Term Disability Benefits. I understand that only the information relating to my ability to work will be shared with my employer. All information will be handled in accordance with applicable Privacy legislation. I further authorize HHI to provide to or exchange with Great West Life information for the purposes of payment of these benefits.

I agree that Homewood Health and my Trustees/Union may also share financial information related to my case for the purposes relevant to the management of the service agreement. I understand that information about me pertaining to this financial information about my case may be reviewed in the event this service agreement is audited.

I agree that my consent is valid for the duration of my case or during any appeal process, but for the purposes of audit, for the duration of the plan. I understand that I can revoke this consent at any time but that without it my case may not be assessed and HHI's ability to assist with my recovery and return to work may be impeded. I agree that a photocopy of this authorization or an electronic version is as valid as the original. Any reference to HHI or the Trustees includes their respective agents and service providers.

Print Name		☐ M ☐ F		Home Phone #	__ __ __ - __ __ __ - __ __ __ __
Mailing Address				Work Phone #	__ __ __ - __ __ __ - __ __ __ __
				Cell Phone #	__ __ __ - __ __ __ - __ __ __ __
City/Town		Prov		Postal Code	
Email Address				Social Insurance Number	__ __ __ - __ __ __ - __ __ __ __
D. O. B. :	_____ /_____ /_____ M D Y	Date of Injury/illness: _____ /_____ /_____ M D Y		Member ID number	
Last Day Worked: ____ /____ /____ M D Y	Have you returned to work? ☐ Yes , date returned to work: ____ /____ /____ ☐ No				
Have you received or do you plan to receive EI benefits? ☐ Yes – Amount per week $_____ ☐ No					
Are you entitled to receive any income from other income replacement plans or sources? ☐ Yes ☐ No Amount of other income $_____ Name of Company_____ Give Details _____					
Your signature				Date	

SHORT TERM DISABILITY APPLICATION FORM

Homewood Health | Santé

NOTE TO PHYSICIAN

Dear Attending Physician: The Motion Picture Workers Health Benefits Trust is interested in supporting ill and injured members in their recovery and safe, timely return to work. Homewood Health Incorporated (HHI) has been requested to review all medical absences exceeding five days, determine if the employee is able to return to work and co-ordinate the employee's recovery and return to work. If you anticipate that a specialist referral or a specific rehabilitation service would assist the Member in their recovery, please indicate below and the Care Manager at HHI will contact you concerning this. Please complete the questions below and fax the completed form to the confidential fax number at **HHI: 1-888 -429-1747**. The Member is responsible for any costs associated with the completion of this form. Thank you for your cooperation.

TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN (Please Print)

Patient's Name: _____

Diagnosis: _____ Date first seen for this illness/injury: _____

DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) diagnosis: _____

Was the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), administered? [ ] Yes [ ] No
If yes, please forward a copy of the completed assessment.

Signs and Symptoms: _____

What specifically prevents your patient from performing their job duties at this time? _____

_____

Is this disability the result of a work related injury/illness? [ ] Yes [ ] No Is this a recurrence? [ ] Yes [ ] No

Is Absence the result of an accident? [ ] Yes [ ] No Date of Accident: (Day/Month/Year): _____

If yes, please describe: _____

Treatment Plan – Please specify and attach information where appropriate: _____

_____

Medication(s)		Dosage	
Physio: [ ] Yes [ ] No	Physio Location		
Lab Work Results		X-Rays Results	
Diagnostic Testing Results		**Please provide copies of test results and consult reports pertaining to this illness/injury.**	
Referral to		Referral Type	

Hospitalization: [ ] Yes [ ] No From: _____ /_____ /_____ M D Y	To: _____/_____/_____ M D Y	Surgery Date: _____ /_____ /_____ M D Y
Is patient compliant with Treatment plan? [ ] Yes [ ] No	Next assessment date: _____ /_____ /_____ M D Y	
Would a referral to a Specialist or specific rehabilitation service be of assistance: [ ] Yes [ ] No Please Describe:		
Date of onset of illness/injury: _____/_____/_____ M D Y	Estimated Return to Work Date: _____/_____/_____ M D Y	

Physician's Name		Phone #	_ _ _ - _ _ _ - _ _ _ _
Address		Fax #	_ _ _ - _ _ _ - _ _ _ _
Physician's Signature		Date	

Physical Capabilities:

Standing/Sitting /Walking	Less than 15 minutes		Less than 30 Minutes	No Limitations	Comments
Standing					
Sitting					
Walking					
Lifting	**No Lifting**	**Less than 10 Kg**	**Less than 25 Kg**	**No Limitations**	**Comments**
Lifting floor to waist					
Lifting waist to shoulder					
Lifting above shoulder					
Climbing	**None**	**2-3 steps**	**4-6 steps**	**No Limitations**	**Comments**
Stairs					
Ladder					
Upper Body Motions	**Right**	**Left**	**Both**	**No Limitations**	**Comments**
Pushing/Pulling					
Carrying					
Gripping					
Reaching Forward					
Reaching Overhead					

Limitations:

Bending or twisting of _____

Repetitive Movement of _____

Restrictions due to medication _____

Operating motorized equipment _____

Cognitive Capabilities: The employee is able to work in the following situations (please circle):

Nature of Work			Additional Comments
Contact with Co workers	Yes	No	
Face: Face with public	Yes	No	
Telephone contact with public	Yes	No	
With Close Supervision	Yes	No	
With Minimal Supervision	Yes	No	
Confrontational Situations	Yes	No	
Frequent deadlines	Yes	No	
Work requiring concentration for example 100% accuracy	Yes	No	
Work requiring critical decision making	Yes	No	
Multi-tasking	Yes	No	
Noisy environment	Yes	No	
Working alone	Yes	No	
Travel	Yes	No	

Estimated duration of modifications: _____ Days or _____Weeks

Effective Date of modifications: _____

Physician's Signature: _____ Date: _____

MOTION PICTURE WORKERS
HEALTH BENEFITS TRUST
c/o IATSE LOCAL 891

SHORT TERM DISABILITY REIMBURSEMENT AGREEMENT

Claimant Name: _____

Address: _____

Union ID Number: _____

Date of accident/injury/occupational disease: _____

☐ WCB or ☐ ICBC Claim Number: _____

I, _____ have made a disability claim to the Motion Picture Workers Health Benefits Plan (the Plan).

1. If I am eligible for the Short Term Disability benefit payments, and I have a legal right to recover damages or compensation from a third party, then my payments from Plan will be reduced.

2. Within 15 days after recovering damages or compensation from a third party I will pay to the Trustees of the Plan the total amount of benefits received from that plan.

3. I will pay all legal fees incurred in pursuing any claim against a third party.

4. I will repay to the Plan the full amount of benefits advanced to me if I fail to comply with this Agreement or if the claim against the third party is abandoned or settled without the written consent of the Plan.

5. For the purpose of this agreement:

   - "third party" includes persons or their insurers who are or may be liable to pay damages or compensation to me arising from my accident/injury or occupational disease and includes WorkSafeBC and any insurance company.

   - "damages or compensation from a third party" includes interest credited as a result of a judgment or settlement.

6. In further consideration of the payments made to me by the Plan I agree:

   - to disclose and authorize my lawyer to disclose to the Plan the receipt of any damages or compensation.

   - to direct my lawyer to release to the Plan the details of any developments or settlement of my claim against a third party.

   - to pay or direct my lawyer to pay to the Plan the total amount of benefits received from that plan within 15 days after receipt of damages or compensation from a third party.

I consent that a copy of this document will be provided to the Plan Administrator, J&D Benefits Inc., for the purpose of record keeping and recovery of benefits as required.

I have read, understood and agree to the above.

_____
Signature of Claimant

Dated this _____/____/_____, at _____, _____
mo day year City Province

_____ _____
Witness Signature Witness Name

DIRECT DEPOSIT AUTHORIZATION

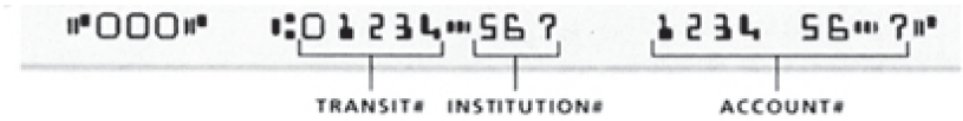
Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account**.

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.



TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)

NAME OF BANK, TRUST CO, CREDIT UNION, ETC.

DATE

SIGNATURE OF EMPLOYEE

AUTORISATION DE DÉPÔT DIRECT

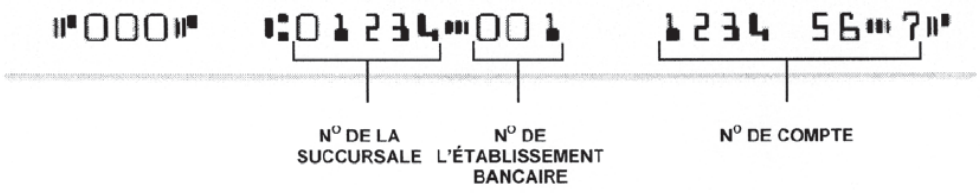
Veuillez remplir la présente autorisation de dépôt direct afin que vos prestations d'invalidité soient déposées directement dans votre compte bancaire. **Toutes les prestations payables aux termes d'un même numéro de régime seront déposées dans le même compte bancaire**.

Inscrivez le nom de votre institution financière, votre numéro de domiciliation, le numéro de l'institution et votre numéro de compte dans les espaces figurant ci-dessous. Vous pouvez vous procurer ces numéros en consultant votre livret de banque, vos relevés bancaires, vos bordereaux de dépôt ou vos chèques personnels, sinon en communiquant avec votre institution financière.

OU BIEN

Veuillez annexer au présent formulaire un modèle de chèque marqué « NUL », comportant les renseignements bancaire, et transmettez-les par télécopieur ou par la poste à votre bureau de gestion de l'assurance invalidité.

Le numéro de votre compte bancaire figure au bas de vos chèques. L'exemple ci-dessous vous aidera à trouver vos données bancaires.



N° DE DOMICILIATION (5 chiffres)	N° DE L'INSTITUTION (3 chiffres)	N° DE COMPTE (12 chiffres)

NOM DE LA BANQUE, COMPAGNIE DE FIDUCIE, CAISSE POPULAIRE, ETC

DATE

SIGNATURE DU SALARIÉ