BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

PROCEDURES TO CLAIM DISABILITY BENEFITS

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

Short Term Disability (STD):

To qualify for STD, a member must have an active hour bank 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 hour bank 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, on the 1st day of surgery 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.

If you return to work and are subsequently disabled due to the same illness or injury, your disability may be considered a recurrent disability and be paid as a continuation of the original claim, providing you have not earned 140 or more employer hours within a 90 day period of the closure of the original disability claim but only if you had not been paid for the maximum benefit period of 40 weeks. If you're disabled after you've returned to work and earned more than 140 employer hours within the 90 day period, the claim would be treated as a new claim.

What you need to do:

- ☐ Contact your medical doctor <u>immediately</u> upon becoming disabled.
- ☐ Obtain a Short Term Disability claim form and EFT (direct deposit form if you want this option) from the Union 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/forms will be your responsibility."

Benefit entitlement may also be paid for a period of up to two weeks for any one disability on the signature of a Chiropractor or Nurse Practitioner. For benefits beyond these two 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. You need to follow treatment instructions while you are disabled. Keep your doctor up-to-date on all counselling or treatment you are receiving to help treat your condition. 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 is liable only when a person undertakes to collect at least the amount of benefits paid and refund the amount paid to the Trust. The third party reimbursement agreement, included with the STD form, 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 Forms for WorkSafe BC Benefits (WSBC).
- ☐ Seek medical assistance either at emergency or at 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. 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.
- ☐ Complete the Reimbursement Agreement included with the STD form.
- ☐ 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/forms will be your responsibility."* Benefit entitlement may also be paid for a period of up to two weeks for any one disability on the signature of a Chiropractor or Nurse Practitioner. For any benefits beyond these two weeks, the signature of a medical doctor will be required.
- ☐ Complete the Reimbursement Agreement.
- ☐ Submit to HHI: the STD claim form, the 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, WSBC wage loss, WSBC vocational rehabilitation benefits, or EI sickness benefits. You must provide cheque stubs or other documentation to J&D Benefits for verification of what period you were on ICBC, WSBC 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.

Long Term Disability (LTD):

To qualify for LTD, a member must have been in receipt of Short Term Disability benefits for the maximum STD benefit period of 40 weeks and continue to be totally disabled. Benefits will be paid for a maximum of an additional 104 weeks. HHI will continue to provide the ongoing assessment of the claim. HHI will notify you if any additional medical information is required. Any cost for completion of medical reports/forms will be your responsibility. If the claim is approved, you will continue to receive benefit cheques by mail or direct deposit.

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 891 website.

Other Benefits

Your benefits include Critical Illness and therefore you may be eligible to make a Critical Illness claim. Contact the IATSE Health Benefits Representative for more details. Forms and information can be found on the 891 website.

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

Name (Last, First)	
Case Number	
DOB (mm/dd/yyyy)	

Return to Work Services - Short Term Disability Application Form

Dear Member:

In order to be eligible for Short Term Disability (STD) 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 your IATSE 891 Benefits of Film representative.

To apply for STD benefits, medical information is required from your physician. Please review and sign the authorization for release of information below, to allow your physician and any caregivers involved in your recovery to share information with Homewood Health Inc. (HHI). Your medical information is kept in the strictest of confidence by HHI case 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 case managers do not share any medical information with your employer or union representatives unless you have provided expressed written consent. The only information HHI case managers provide to your Union 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 you inform the IATSE 891 Benefits of Film representative of your absence at 604-664-8914
2. Complete the Member Information section of this document.
3. Sign the Authorization to Release Medical Information. If you have any questions please call 1 888 689-8604.
4. Have your doctor complete the Physician section in detail; you are responsible for any costs associated with the completion of this form.
5. You are responsible to urgently fax or scan the fully completed and signed form (5 pages) directly to HHI at-1-888-429-1747 **or by secure scan to: disabilitymanagement@homewoodhealth.com.** HHI will review your claim and advise both you and the IATSE 891 Benefits of Film representative of the outcome. Your application for STD must be received by HHI within 60 days of the date of your injury/illness. Failure to submit within the time frame may result in delay or in the application being denied.

Member Information To Be Completed by the Member (Please print)

Member Name: (Last, First, Middle Initial)	SIN #:	ID#
Home Phone Number: (+ Area Code)	Cell Phone Number: (+ Area Code)	☐ Male ☐ Female
Address: (Street, City, Province, Postal Code)		
Job Title	Email Address	Preferred Language: ☐ English ☐ French
Date of Birth: (mm/dd/yyyy)	Last Day Worked: (mm/dd/yyyy)	Date of Illness: (mm/dd/yyyy)
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		

Name (Last, First)									
Case Number									
DOB (mm/dd/yyyy)									

If yes, Amount of other income $ _____ Name of Company _____ Details:_____

Member's Authorization for Release of Information (signature required)

I hereby authorize Homewood Health Inc. (HHI) to collect, 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 agree that HHI and my Trustees/Union may also share financial information related to my case with Canada Life and J&D Benefits for the purposes relevant to the management of the service agreement. I understand that information about me pertaining to the financial information about my case may be reviewed in the event this service agreement is audited.

I further authorize HHI to collect, use or disclose with J&D Benefits and Canada Life information for the purposes of payment of all benefits that I may be entitled to under the MPWHBT.

I further authorize HHI to use all related medical information from my STD file 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 Union and J&D Benefits. All information will be handled in accordance with applicable Privacy legislation.

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.

Member Signature: _____ **Date**: _____

Name (Last, First)	
Case Number	
DOB (mm/dd/yyyy)	

Dear Attending Physician

The Benefits of Film IATSE 891 Active Health Plan is interested in supporting ill and injured members in their recovery and ensuring a safe, timely return to work. Homewood Health Inc. has been retained by the employer/trust to review your patient's medical absence exceeding five days to determine when the patient is able to return to work safely and to co-ordinate the patient's recovery and return to work. The purpose of this statement is to assist HHI in determining your patient's eligibility for STD benefits and for planning and managing an early and safe return to work. Any fee required for completion of this form is the responsibility of the patient. Your assistance is greatly appreciated. **Completed form may be faxed to HHI at 1-888-429-1747.**

To Be Completed by the Physician (Please Print)

Patient Name:	Date of Birth: (mm/dd/yyyy)

Nature of Illness – Please select appropriate ICD10 Diagnostic Category :

- ☐ A00-B99 Certain infectious and parasitic diseases
- ☐ C00-D49 Neoplasms
- ☐ D50-D89 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
- ☐ E00-E89 Endocrine, nutritional and metabolic diseases
- ☐ F01-F99 Mental, Behavioral and Neurodevelopmental disorders
- ☐ G00-G99 Diseases of the nervous system
- ☐ H00-H59 Diseases of the eye and adnexa
- ☐ H60-H95 Diseases of the ear and mastoid process
- ☐ I00-I99 Diseases of the circulatory system
- ☐ J00-J99 Diseases of the respiratory system
- ☐ K00-K95 Diseases of the digestive system
- ☐ L00-L99 Diseases of the skin and subcutaneous tissue
- ☐ M00-M99 Diseases of the musculoskeletal system and connective tissue
- ☐ N00-N99 Diseases of the genitourinary system
- ☐ O00-O9A Pregnancy, childbirth and the puerperium
- ☐ Q00-Q99 Congenital malformations, deformations and chromosomal abnormalities
- ☐ R00-R99 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- ☐ S00-T88 Injury, poisoning and certain other consequences of external causes

Primary Diagnosis:

Secondary Diagnosis and/or Complications:

Name (Last, First)	
Case Number	
DOB (mm/dd/yyyy)	

If childbirth, expected or actual delivery date: (mm/dd/yyyy)	☐ Vaginal ☐ C-section
Occupational Illness/Injury: ☐ Yes ☐ No	If yes, date of event: (mm/dd/yyyy)
Auto accident: ☐ Yes ☐ No	If yes, date of event: (mm/dd/yyyy)
Date of first visit to you pertaining to this condition:	First date of work absence due to condition:
Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No	If yes, date: (mm/dd/yyyy)

Hospitalization Is/Was patient hospitalized: ☐ Yes ☐ No

Date of Admittance (mm/dd/yyyy): _____ Date of Discharge (mm/dd/yyyy): _____

If surgery was performed please provide date and description of surgery:

Date: (mm/dd/yyyy)_____ Description: _____

Treatment (Medication, Dosage, Physiotherapy, Other):

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Prognosis Please provide the prognosis for recovery:

Estimated date for return to full duties and hours of work: (mm/dd/yyyy)

Date of next appointment with you: (mm/dd/yyyy)

Please indicate if your patient has or will be seen by a specialist for this condition: ☐ Yes ☐ No

Name of Specialist:	Specialty:	Date of Visit: (mm/dd/yyyy)

Please describe your patient's functional ability:

Name (Last, First)	
Case Number	
DOB (mm/dd/yyyy)	

Based on your clinical findings and observations, please describe your patient's current cognitive and/or physical restrictions and limitations:

Please indicate how long these restrictions and limitations should be in place: _____

"The CMA recognizes the importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness. Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. A safe and timely return to work benefits the patient/employee and his or her family by enhancing recovery and reducing disability." -- 2013 Canadian Medical Association Policy Statement

Please indicate the date your patient should be ready to return to some form of work, bearing in mind that restrictions or limitations could be accommodated:_____

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

Note to Physician:
The information in this statement will be kept in a disability benefits file at Homewood Health and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Please affix office stamp or complete the following:

Name of Attending Physician: (please print)	Physician's Specialty:	Telephone Number:
Address:		Fax Number:
Signature:		Date: (mm/dd/yyyy)

Thank you for your assistance.
Please send the completed form to Homewood Health via confidential fax at 1-888-429-1747

For assistance with this form, please contact Homewood Health Inc. at disabilitymanagement@homewoodhealth.com.

Name (Last, First)									
Case Number									
DOB (mm/dd/yyyy)									

BENEFITS OF FILM

IATSE 891 | ACTIVE HEALTH PLAN

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

SHORT TERM DISABILITY REIMBURSEMENT AGREEMENT

Claimant Name: _____

Address: _____

Union ID Number: _____ Group Number: _____

Date of accident/injury/occupational disease: _____

☐ WCB Claim Number: _____

☐ Other 3rd party 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.

    - "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