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 disabled and prevented from performing the essential duties of your own occupation.

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 active hour bank coverage on the 1st day of disability in order to receive benefits. Benefits are paid pro-rata based on 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 have 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 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.
- Complete the Member Information and Member Authorization sections of the claim form and sign it.
- Ask your Medical Doctor or Nurse Practitioner 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."

Short Term Disability benefits may also be paid for a period of up to two weeks for any one disability on the signature of a Chiropractor. For benefits beyond these two weeks, the signature of a Medical Doctor or Nurse Practitioner will be required.

Benefits can also be paid for a period of up to two weeks on the signature of a licensed dentist or oral surgeon, for disabilities within their scope of practice. For benefits beyond these two weeks, the signature of a medical doctor or nurse practitioner 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.
  - o Members are encouraged to file a claim as soon as possible. In no circumstances will benefits be paid retroactive more than 6 months from the date the claim is received by HHI.
- → 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 Member sections of the STD claim form and sign it.
- ☐ Ask your medical practitioner to complete the Physician's Statement on 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 Dentist. For any benefits beyond these two weeks, the signature of a medical doctor or Nurse Practitioner 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 be unable to perform the essential duties of any occupation for which they are qualified. 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 at www.iatse.com under Membership\Resources.

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 Benefits of Film website – www.benefitsoffilm.com.

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

Short Term Disability - Attending Physician's Statement and Member Authorization

Member Information and Consent to Be Completed by the Member (Please print)		
Name: (Last, First, Middle Initial)	**Account Name** IATSE 891 Benefits of Film	
Primary Contact Number: (+ Area Code) ☐ Home ☐ Cell	Cell Phone Number: (+ Area Code)	Your preferred pronoun: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other
Address: (Street, City, Province, Postal Code)		
Email Address:	Job Title:	Preferred Language: ☐ English ☐ French
Date of Birth: (mm/dd/yyyy)	Last Day at Work:	First Day of Missed Work:

Member's Authorization for Release of Information

I authorize Homewood Health Inc. (HHI) to collect, use and disclose information and documents pertaining to my Short-Term Disability (STD) case with my physician(s) or other health care providers involved in my care, for the purpose of determining my eligibility for disability benefits under the IATSE 891 Benefits of Film Active Plan, and managing my medically supported absence. I also authorize HHI to share my personal information with 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 can share information about me with the other insurers or benefit providers for the purpose of coordinating policies and determining eligibility for benefits. I agree that HHI, the Trustees/Union, J&D Benefits and Canada Life may exchange information, including my financial information, for the purpose of benefit payments and financial administration of the STD plan.

I further authorize HHI to use the information in my STD file should I need to apply for Long Term Disability (LTD) benefits, for the purpose assessing my LTD claim. I understand that information relating to my functional abilities, ability to work and ongoing entitlement to STD benefits will be shared with my Union and J&D Benefits; no medical information will be shared with my employer. All information will be handled in accordance with applicable Privacy Legislation.

I agree that my consent is valid for the duration of my claim and during a file audit. I understand that I can revoke this consent at any time, but that without it my claim 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 electronic version is as valid as the original.

NOTE: in cases where safety or risk of life to yourself or others is a concern, HHI is required to take responsible action. This may mean notification to a spouse, physician or other authorities. If you are working in a Safety Sensitive Position, this will also mean notification to your employer and/or union. The reason for this is to assist in reducing the risk of harm to yourself, your co-workers and the public in general.

Member Signature: ______________________________ Date: ______________________________

Any fee required for completion of this form is the responsibility of the patient

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

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Dear Attending Physician

Homewood Health Inc. has been retained by the IATSE Local 891 Employee Life and Health Trust to review your patient's absence to adjudicate their eligibility for STD benefits to determine when the patient is able to return to work. They are interested in supporting ill and injured members in their recovery and ensuring a safe, timely return to work. The information you provide will be used to assist with planning and managing an early and safe return to work. Your assistance is greatly appreciated.

To Be Completed by the Physician (Please Print)

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

Nature of Illness – Please select appropriate ICD-10 Diagnostic Category:

	Code	Category		Code	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	☐	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, which may be impacting your patient's level of function or the expected recovery period

Date of first visit to you for this absence:

First date of work absence due to this condition:

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No
If yes, date:

Related to Motor Vehicle Accident?
☐ Yes ☐ No

Hospitalization Is/Was patient hospitalized: ☐ Yes ☐ No

Date of Admittance: Date of Discharge:

If absence is related to childbirth, expected or actual delivery date:

Surgery If surgery was performed, please provide:
Date: Description: Usual recovery time for surgical procedure:

Date of next appointment with you:

Occupational Illness/Injury: ☐ Yes ☐ No
If yes, has medical been submitted to the compensation board? ☐ Yes ☐ No

Treatment (Medication, Dosage, Physiotherapy, Other):

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

Estimated date for return to full duties and hours of work:

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*"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*

Homewood Health subscribes to the benefits of early and safe return to work; your responses to the questions below will assist in making recommendations to your patient's employer regarding possible accommodations that could limit the time away from work.

Please describe your patient's functional ability - tasks and activities your patient **can perform** (e.g.: prepare meals, manage finances, operate a vehicle, regular exercise program, etc.). This will be used to assist in determining possible accommodations.

Based your clinical findings and observations, please describe your patient's current cognitive and/or physical **restrictions and limitations** (e.g.: no lifting greater than 10 lbs, no prolonged sitting, unable to multi-task, unable to perform tasks that require tight deadlines, etc.)

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

Considering your patient's restrictions and limitations, would they be able to work in a different setting? ☐ Yes ☐ No

If no, please explain:

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

Name of Specialist:	Specialty:	Date of Visit:

Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in the patient's file with Homewood Health Inc. and may be disclosed to the patient and/or those authorized by him/her unless I (the physician) notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

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

Please send the completed form to Homewood Health via confidential fax at 1-888-429-1747 or by email to disabilitymanagement@homewoodhealth.com

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DIRECT DEPOSIT AUTHORIZATION

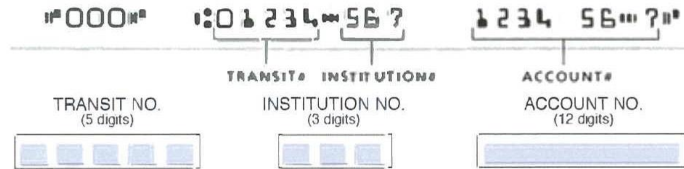
Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account.**

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.



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

DATE

SIGNATURE OF EMPLOYEE

DISABILITY BENEFITS REIMBURSEMENT AGREEMENT

Claimant Name: ____

Address: ____

Union ID Number: _______________

Date of accident/injury/occupational disease: __________________________________

☐ WCB Claim Number: ____

☐ Other 3rd party Claim Number: ____

I, ________________________ have made a disability claim to the IATSE Local 891 Employee Life and Health Trust (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.

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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