CANADIAN ELEVATOR INDUSTRY WELFARE PLAN

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 | CERTIFICATE NUMBER | GROUP PLAN NUMBER

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 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, medical facility, any insurance company or government body and any other person or institutions to release relevant information to Manion, Wilkins & Associates Ltd solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

   _____ _____

   Member's Signature Date

SECTION 2 - TO BE COMPLETED BY YOUR LOCAL BUSINESS REPRESENTATIVE ***(please print)***

1. On what date did this member last work? Day Month Year Number of hours:
2. If Member became disabled while on Layoff, what was the date he/she was recalled and was unable to report to work? Day Month Year
3. Is this disability due to an occupational sickness or injury? [ ] NO [ ] YES
   If "YES" has a claim been made for Workers' Compensation benefits? [ ] NO [ ] YES
4. Date returned to work: _____

Signed by: _____ Title: _____ Date: _____

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

Trust Fund Office: Manion Wilkins & Associates Ltd., 500-21 Four Seasons Place, Etobicoke, Ontario M9B0A5 Telephone: (416) 234-5044

1 1-800-263-5621