D.A. Townley

4250 CANADA WAY, BURNABY, BC V5G 4W6
TEL: (604) 299-7482 FAX: (604) 299-8136
TOLL-FREE: 1-800-663-1356 www.datownley.com

Notice to Employee:
Employer to complete appropriate section.
Doctor to complete Attending Physician's Statement on reverse.
Claimant must be seen and treated by a Medical Doctor during period of disability.
* **Employee MUST sign both sides of form where indicated.**
Employee MUST submit a completed Direct Deposit form along with a copy of a VOID cheque to the administrator in order for the payment to be processed. Please ensure all documents are submitted on one email.
If applicable under the terms of your contract, you will be required to make application for Employment Insurance sick benefits.
If your benefits are taxable, Income Tax will be deducted from your benefit payments.
Email: wiclaims@datownley.com

WAGE INDEMNITY BENEFITS CLAIM

(Claim must be filed within 30 days of becoming disabled.)

1. Member Last Name First Name

2. Member Address

3. City	4. Province	5. Postal Code	6. Telephone ( )
7. Social Insurance Number	8. Date of Birth (yr/mo/day)	9. Sex ☐ Male ☐ Female	10. ☐ Married ☐ Single ☐ Other

11. Date last worked	12. When did you become totally disabled (unable to work) Date Time A.M./P.M.
13. If hospitalized, give name of hospital	14. Dates confined to hospital IN OUT
15. If returned to work, give date	16. If not, give date you expect to return to work
17. Name of attending physician **(please print)**	18. Doctor's address

19. Nature of disability

20. Accident Information — Complete only if claim is a result of injuries sustained in an accident.

Date of Accident	Time of Accident	Was work being done for an employer at the time of the accident?	If not at work, where did accident happen?
	at A.M. P.M.	☐ Yes ☐ No	

21. Describe how accident happened

22. Are you receiving Employment Insurance Benefits? ☐ Yes If Yes, for what amount? ______
weeks in total: ☐ No For what period? From: ______ To: ______

23. Have you been self-employed or employed elsewhere during this period of disability? If "YES", explain.
PLEASE NOTE: Should this change at any time during the duration of your claim, you must advise D.A. Townley of the details.

24. Are you entitled to any Disability Income Benefits provided by a government agency? ☐ Yes ☐ No
25. Are you entitled to any Disability Income under any other plan of group insurance? ☐ Yes ☐ No
26. If "YES", give policy number, name and address of the organization providing such benefits:

I understand that D.A. Townley collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

* Employee Signature ______ Date ______
(This must be signed before claim can be assessed)

TO BE COMPLETED BY EMPLOYER

Name of employer			Group #
Address			Union affiliation (if applicable)
Date last worked and number of hours worked	Has employee been laid off? (if so, when)	Has employee returned to work? (if so, when)	Has employment been terminated? (if so, when)

Is disability due to occupational sickness or injury? ☐ Yes ☐ No	Has claim been filed with Workers' Compensation? *(If yes, date filed)* ☐ Yes ☐ No
Occupation:	Average weekly earnings $

Remarks

Signed (employer's representative)	Date	Contact Email

***IMPORTANT* Please attach a detailed job description to this form**

PATIENT AUTHORIZATION

Name **(PLEASE PRINT)**

DATE OF BIRTH		
Year	Month	Day

I hereby authorize the release, to D.A. Townley and my insurer, any information required in connection with this claim. The information released through this authorization is to be used for claims adjudication purposes and statistical analysis. Photocopy of this authorization shall be valid as the original.

DATE		
Year	Month	Day

* PATIENT'S SIGNATURE ____________________

(This must be signed before claim is assessed.)

ATTENDING PHYSICIAN'S STATEMENT (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 — Year | Month | Day
   (b) has patient had same or similar condition ☐ Yes ☐ No If "Yes", please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

4. If patient is/was pregnant, indicate due date or date of confinement. — Year | Month | Day

5. Date of hospital admission — Year | Month | Day   Date of discharge — Year | Month | Day

6. Nature of treatment (eg. date and type of surgery*, treatment including medication, dosage and frequency) *Was this done under General Anesthetic?
   ☐ Yes ☐ No

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 physicians and provide a copy of consultation reports.

8. (a) Date of first and all subsequent visits during present period of absence from work (year, month, day)

   (b) Were you actively supervising this patient's care during the full period?
   ☐ No If "No", please comment in remarks
   ☐ Yes If "Yes", state frequency ☐ 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 Year | Month | Day   TO: (inclusive) Year | Month | Day

   (b) If still unable to work, give approximate date when patient should be able to return **or** the estimated number of weeks before possible return — Year | Month | Day

10. (a) How does present condition affect patient's ability to work? (eg. restrictions, limitations, proposed surgery etc.)

    (b) Is patient fit for trial return to work on part-time or modified basis?
    ☐ Yes ☐ No If "Yes", indicate date — Year | Month | Day

    (c) Is patient a suitable candidate for a vocational rehabilitation program? ☐ Yes ☐ No

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

Name of attending physician (Print)		Specialty (Print)	Physician's Stamp Here
Telephone Number ( )	Signature	Date yr/mo/day	

Any charge for completing this form is patient's responsibility.

D.A. Townley

4250 Canada Way, Burnaby, B.C. V5G 4W6 Tel: (604) 299-7482 Fax: (604) 299-8136 Toll free: 1-800-663-1356

Direct Deposit Registration Form

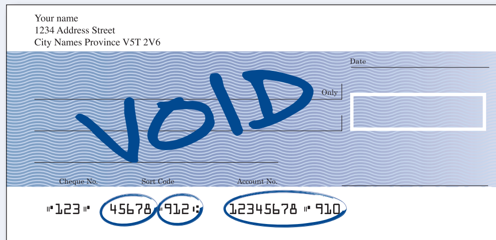
To benefit from the convenience of receiving your claims payments by pre-authorized direct deposit, you must complete the following steps:

Complete this form and return along with a scanned void cheque to us by email: (PLEASE PRINT CLEARLY)

Employer Name			Group Policy Number(s)	
Surname	First	Initial	ID Number	
Address	City		Province	Postal Code
Email Address (Mandatory)		Birthdate Year / Month / Day	Telephone ( )	

Name of Financial Institution			☐ Chequing Account	☐ Savings Account
Branch Address	City	Province	Telephone ( )	

Please attach either a Void Cheque or a Direct Deposit Authorization form, completed by your financial institution, which verifies your complete bank account encoding information.



I authorize D.A. Townley (DAT) to transfer funds via direct deposit to the account designated above. I understand that this authorization will remain in effect until terminated in writing by me or DAT. I agree that DAT will have no further liability with respect to any payments made in accordance with this authorization. I elect to receive my Explanation of Benefits in relation to my claim online via the Plan's Member website. I authorize DAT, its agents, consultants or service providers, my financial institution, health care providers, other financial institutions, insurance and reinsurance companies, government agencies and depart-ments, employers and former employers, my local union and plan trustees, actuaries and auditors to exchange my personal information, when necessary to administer the plan. I authorize and direct the financial institution designated above to correct overpayments credited to my account during or after my lifetime by debiting my account and refunding such overpayments to DAT at its sole discretion. When providing informa-tion for my Spouse or Dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Signature	Date

Direct Deposit for Claims Reimbursement

D.A. Townley now offers “Direct Deposit for Claims Reimbursement”. In order to take advantage of this service, we require some information from you. The following is a list of questions we think will help you.

CONCERNED ABOUT PRIVACY?

- We are committed to protecting your personal information and use your information solely for the purpose of administering your benefit plan.
- We do not disclose your information without your permission, except in limited circumstances as permitted or as required by law.
- A copy of our Privacy Policy is available upon request or at www.datownley.com

HOW DO I CANCEL DIRECT DEPOSIT?

- Your Direct Deposit request will remain in effect until you change your banking information or cancel the service.
- To cancel the service, please contact us at (604) 299-7482.

KEEPING YOUR DETAILS UP TO DATE

- It is important that we have your current contact details, including your email address. If there is a change to these details, please contact us immediately.
- If you want to change the account into which your payments are being deposited, you will need to complete a new Direct Deposit Registration Form. Remember not to close your current account until you have provided your updated details to us.

NEED MORE INFORMATION?

If you have any questions or need help to complete this form, please contact us at 1-800-663-1356 or (604) 299-7482.