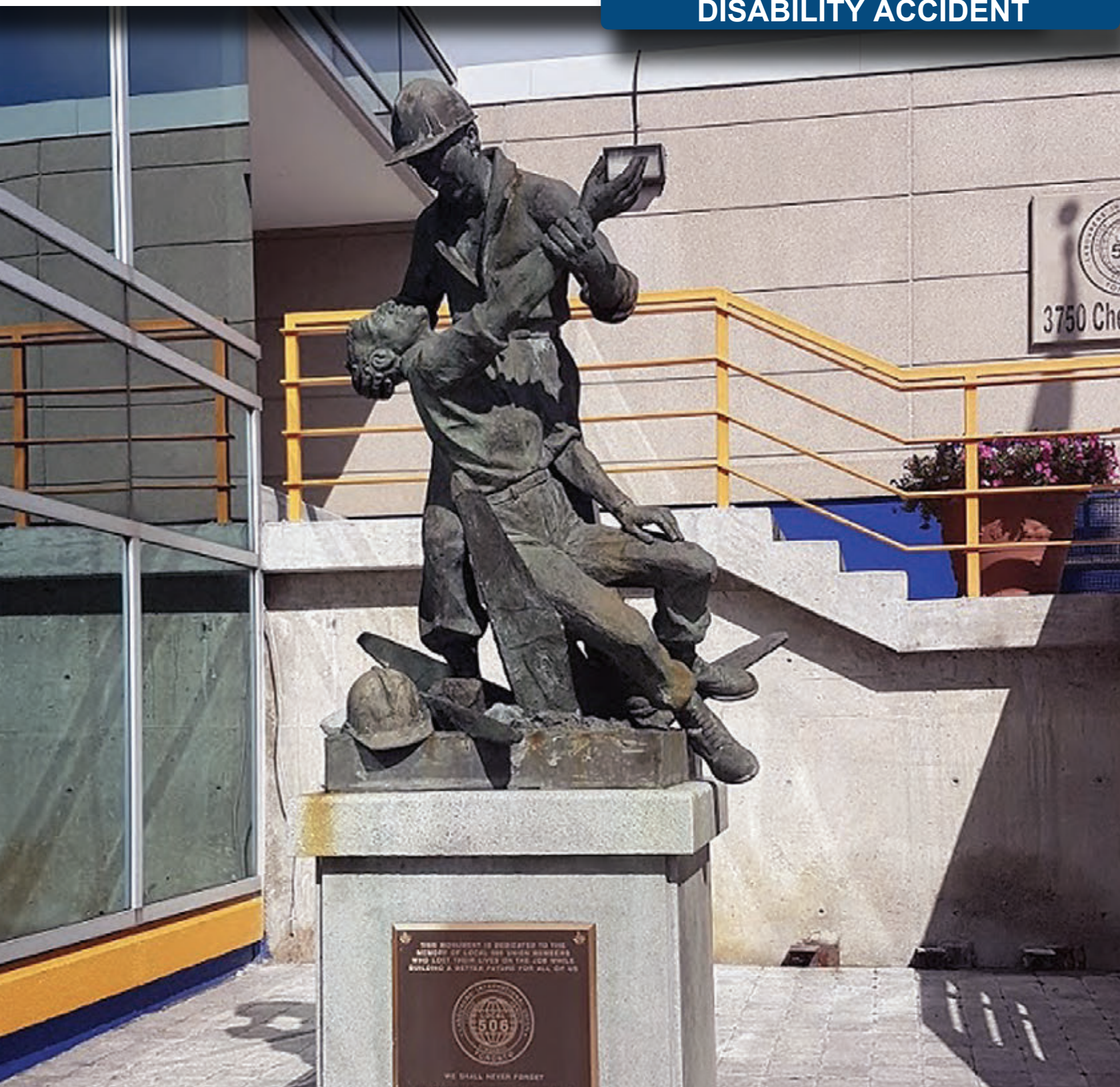
LiUNA!care
LOCAL 506 TM
BUILDING HEALTHY FUTURES

Labourers' Union Local 506
Members Benefit Trust Fund
ACTIVE MEMBERS

PERMANENT AND TOTAL DISABILITY ACCIDENT



LABOURERS' UNION LOCAL 506
MEMBERS BENEFIT TRUST FUND
- ACTIVE MEMBERS -

PERMANENT AND TOTAL DISABILITY ACCIDENT

SUBMISSION INSTRUCTIONS:

- Member (or Power of Attorney) to complete and sign Claimant's Statement and Authorization Form.

- Attending Physician to complete and sign the Physician's Statement.

- Policy No. SG10395004. Please keep a copy of completed application package for your records to substantiate your claim.

- Send completed application and supporting documents via fax, e-mail or mail to:

LiUNAcare Local 506
3750 Chesswood Drive, Suite 1
Toronto, ON M3J 2W6

Tel: 416-506-8841
Fax: 416-506-8833
Email: lifeeventclaims@bpagroup.com
Web: www.liunacare506.com

CHUBB

PERMANENT AND TOTAL DISABILITY CLAIMANT'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

TO BE COMPLETED BY THE CLAIMANT.		
Policy Number:	**Claim No.:**	
Name:		
Address:		
City:	**Province:**	**Postal Code:**
Sex: ☐ **Male** ☐ **Female**	**Date of Birth:**	
Date of Accident:		
Description of Accident (State where and how):		
Date First Unable to Work:	**Date First Medical Attendance:**	
Date Returned to Work:	**Expected Return to work:**	
Have you had same or similar condition? ☐ **No** ☐ **Yes**		
Describe:		
Name of Physicians:	**From:**	**To:**
Address:		
Name of Physicians:	**From:**	**To:**
Address:		
Name of Hospitals:	**From:**	**To:**
Address:		
Name of Hospitals:	**From:**	**To:**
Address:		
Have you applied for or are you received: ☐ **C.P.P./Q.P.P.** ☐ **Employer Disability** ☐ **Automobile Ins.** ☐ **W.C.B./W.S.I.B.** ☐ **Other**		
If yes, where applicable, please provide name:		
Insurer:		
Policy Number:	**and in any case, the amount of benefit: $**	

EMPLOYMENT DETAILS

Name of Employer:	**Occupation:**
Date of Hire:	**Last Day Worked:**
Hours Worked / Week	

EDUCATION / VOCATIONAL BACKGROUND

Level of Education:	**Date Completed:**
Other Courses / Training	
Past Types of Employment:	

IMPORTANT: PLEASE COMPLETE AND SIGN THE ATTACHED AUTHORIZATION FORM.

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Name (Please Print): _____

Signature _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION (CLAIMANT)

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

Name of Insured:

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning myself to give to Chubb Insurance or Chubb Life Insurance all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as a claimant and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this consent shall be as valid as the original.

Name (Please Print) _____ Signature _____

Dated at _____ of _____
City/Town Region/Municipality

In the Province of _____ on this _____day

of _____.
Month and Year

Signature of Patent/Guardian if Child is a Minor _____

CHUBB

PERMANENT AND TOTAL DISABILITY ATTENDING PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

AUTHORIZATION OF PATIENT

Policy Number(s):	**Name:**	
Address:		
City:	**Province:**	**Postal Code:**

I hereby authorize the release to Chubb Insurance and/or Chubb Life Insurance Company of Canada of the information requested in this form.

Signature_____ Date _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Name:	**Date of Birth:**

HISTORY

Check One: ☐ Accident ☐ Sickness
When did symptoms first appear or accident happen?
Date patient ceased work because of disability:
Has patient ever had same or similar condition? ☐ Yes ☐ No State when & describe:
Is condition due to injury or sickness arising out of employment? ☐ Yes ☐ No ☐ Unknown
Names of any other treating Physicians:
Address:

DIAGNOSIS (if applicable)

Primary:
Secondary (if applicable):
Subjective Symptoms:
Objective Findings (x-rays, laboratory, EKG, clinical findings):

TREATMENT

Date of First Visit:
Date of Latest Visit:
Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify):
Date of Hospitalization: Confined From: To:

NATURE OF TREATMENT

PHYSICAL IMPAIRMENT

Degree of Limitation of Functional Capacity:
☐ **Class 1 – No limitation of functional capacity: capable of heavy physical activity, no restrictions. (0 - 10%)**
☐ **Class 2 – Slight limitation of functional capacity: capable of light manual activity. (15 - 30%)**
☐ **Class 3 – Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity. (35 - 55%)**
☐ **Class 4 – Marked limitation. (60 - 70%)**
☐ **Class 5 – Severe limitation of functional capacity: incapable of minimal (sedentary) activity. (71 -100%)**

MENTAL/NERVOUS IMPAIRMENT (if applicable)

☐ **Class 1 – Able to function under stress and engage in interpersonal relations. (No limitations)**
☐ **Class 2 – Able to function in most stress situations and engage in most interpersonal relations. (Slight)**
☐ **Class 3 – Able to engage in only limited stress situations and limited interpersonal relations. (Moderate)**
☐ **Class 4 – Unable to engage in stress situations or engage in interpersonal relations. (Marked)**
☐ **Class 5 – Significant loss of psychological, personal and social adjustment. (Severe)**

PROGRESS

Is patient: ☐ **Ambulatory** ☐ **House Confined** ☐ **Bed Confined** ☐ **Hospital Confined**
Limitation which prevents return to own occupation?
Limitation which prevents return of any other occupation?

PROGNOSIS

Is patient now totally disabled from Own job? ☐ **Yes** ☐ **No**	**Any other Job:** ☐ **Yes** ☐ **No**
If yes, please indicate when patient will be capable of performing duties of:	
Own Job: ☐ **1-3 Months** ☐ **3-6 Months** ☐ **Never** ☐ **Other (Specify):**	
Any Other Job: ☐ **1-3 Months** ☐ **3-6 Months** ☐ **Never** ☐ **Other (Specify):**	
If no, please indicate date patient will be able to perform duties on:	

VISUAL (if applicable)

What was vision at latest observation?	**With glasses:**	**O.D.**	**O.S.**
	Without glasses:	**O.D.**	**O.S.**
Vision can be restored in whole or part by:	**O.D.** ☐ **Lenses** ☐ **Treatment** ☐ **Operation** ☐ **Not Restorable**		
	O.S. ☐ **Lenses** ☐ **Treatment** ☐ **Operation** ☐ **Not Restorable**		

REMARKS

Name of Attending Physician:	**Degree:**	
Phone #: ( )	**Fax #: ( )**	
Address:		
City:	**Province:**	**Postal Code:**

Signature_____ Date _____