



# SEAFARERS' MEDICAL PLAN

1333 ST. JACQUES  
MONTREAL, QUEBEC H3C 4K2  
TEL: (514) 931-7859

THIS FORM IS TO BE COMPLETED

- 1) IF YOU ARE CLAIMING FOR SHORT TERM WAGE LOSS BENEFITS, OR
- 2) IF YOU WISH TO HAVE YOUR DISABILITY PERIOD COUNTED AS A SAILING PERIOD

## STATEMENT BY THE SEAFARER

PLEASE MAKE SURE THAT ALL QUESTIONS ARE ANSWERED

NAME OF SEAFARER		UNION NUMBER				NAME OF EMPLOYER COMPANY		NAME OF LAST SHIP	
SOCIAL INSURANCE NUMBER		AGE	D	M	Y	RATING		DATE OF TERMINATION	
ADDRESS				APT.		DID ACCIDENT OR SICKNESS OCCUR ABOARD SHIP? YES <input type="checkbox"/> NO <input type="checkbox"/>			
CITY		PROV.	POSTAL CODE			IF WORK ACCIDENT, WAS SAME REPORTED TO THE COMPANY, CAPTAIN OR OFFICER-IN-CHARGE? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PHONE NUMBER ( ) -		NAME OF SPOUSE							
IS SPOUSE A S.I.U. MEMBER?		IF SO, UNION NO.:				DID YOU APPLY FOR BENEFITS FROM THE UNEMPLOYMENT INSURANCE COMMISSION? YES <input type="checkbox"/> NO <input type="checkbox"/>			
NAMES OF DEPENDENT CHILDREN		AGE	D	M	Y	DO YOU WISH TO APPLY FOR SHORT TERM WAGE LOSS BENEFITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
						IF SO, ENCLOSE A LETTER FROM THE UNEMPLOYMENT INSURANCE COMMISSION STATING THE PERIOD YOU WERE IN RECEIPT OF THEIR BENEFITS. IF YOUR CLAIM WAS REFUSED BY THE UNEMPLOYMENT INSURANCE COMMISSION, ENCLOSE THEIR LETTER OF REFUSAL.			

I HEREBY CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE.

THE SEAFARERS MEDICAL PLAN RESERVES THE RIGHT TO HAVE THE SEAFARER EXAMINED BY A PHYSICIAN OF ITS CHOICE BEFORE AWARDING ANY WAGE LOSS BENEFITS OR CREDITING DAYS OF DISABILITY AS SAILING DAYS.

SIGNATURE OF SEAFARER \_\_\_\_\_

DATE \_\_\_\_\_

## ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME		AGE	MEDICARE NO.
DIAGNOSIS (DESCRIBE COMPLICATIONS IF ANY)			
IF HOSPITALIZED GIVE NAME OF HOSPITAL		DATES OF HOSPITALIZATION	
TREATMENT & MEDICATION PRESCRIBED			
RESPONSE TO TREATMENT			
IF REFERRED TO SPECIALIST, GIVE NAME AND ADDRESS			
WHEN DID THIS PATIENT FIRST CONSULT YOU FOR THIS CONDITION?			
DATES OF EACH FOLLOW-UP VISIT			
THIS PATIENT HAS BEEN INCAPACITATED FROM:		TO:	
IF STILL INCAPACITATED, GIVE APPROXIMATE DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK			

NAME OF PHYSICIAN \_\_\_\_\_ (PRINT OR TYPE PLEASE) CERTIFIED SPECIALIST? \_\_\_\_\_

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE.

DATE \_\_\_\_\_ 199 \_\_\_\_\_ SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_