IUOE Local 793

Pension and Benefits
Administered by OEBAC

Attending Physician's Statement

Short Term Disability Claim

A Introduction

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

Plan Member: You must complete and sign Section B of this form. Once done, please provide it to your Attending Physician.
Attending Physician: Your Statement is used to assist the Operating Engineers Benefits Administration Corporation (OEBAC) in the decision on your patient's short-term disability benefits claim. Please complete Sections C and D and return to OEBAC using the options on the back of this form.

B Plan Member Authorization

For office use only
ABCDEFGH

First name	Middle name or Initial	Last name(s)	From your OEBAC Benefits Card
			Group #: ☐ 793 ☐ 793X
Date of birth ((yyyy-mm-dd)	Date form provided to physician (yyyy-mm-dd)		Certificate #:
			Or, from your IUOE Local 793 Card Registration #:

By signing this form, I confirm

1) My authorization to the doctor named below to provide to OEBAC and its agents my medical information to support my short-term disability benefits claim, which includes but is not limited to, copies of consultation reports, clinical notes, test results, and hospital records.
2) My authorization to OEBAC and its service providers to use this information when assessing my claim and administering the plan.
3) My agreement that this authorization is valid throughout the duration of my claim, during the resolution of any decision relating to my claim that I may have disputed, and for the duration of the Plan.
4) My agreement that a photocopy of this authorization or electronic version is as valid as the original.
5) My understanding that OEBAC will help me pay for the cost of the Attending Physician's Statement by reimbursing me up to $100.00 and that any money owing over this amount is my responsibility.

Printed Name	Signature	Date (yyyy-mm-dd)

C To be completed by the Attending Physician

For office use only
ABCDEFGH

Primary Diagnosis:
Secondary Diagnosis:
Complications:

The disability is related to: ☐ illness ☐ accident ☐ occupational illness ☐ occupational accident ☐ motor vehicle accident

Date of the event (yyyy-mm-dd):

If condition is due to pregnancy, what is (or was) the expected date of delivery (yyyy-mm-dd)?

First date of work absence due to current disability (yyyy-mm-dd)	Recovery Prognosis Date (yyyy-mm-dd)	Anticipated Return to Work Date (yyyy-mm-dd)

Has your patient been referred to another physician: ☐ Yes ☐ No

If "Yes", please provide the Name of the Physician _____ and the Specialty:_____

Has the patient undergone or will undergo any of the following? (If you select "Yes" to any, please provide the information requested below it)

Examinations or tests ☐ Yes ☐ No	Surgery ☐ Yes ☐ No	Hospitalization ☐ Yes ☐ No
Specifics:	Date (yyyy-mm-dd):	Hospital:
	Procedure:	Admission (yyyy-mm-dd):
	Day Surgery? ☐	Release (yyyy-mm-dd):

D Physician's/Health Care Professional's acknowledgement and authorization

I confirm that, to the best of my knowledge all of the information I have provided in this report is accurate and complete.

I acknowledge that the information in this statement will be kept in a group life, health or disability benefits file with OEBAC and may be accessed by the patient and third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Name of Attending Physician (please print)	Address and telephone number (Please print or use a stamp)
Physician's Signature X	
Date (yyyy-mm-dd)	

Once you completed this Statement, please return it to your patient or send it to OEBAC using one of the three methods described below, retaining the originals for your records.

MAIL this form and all its attachments (no staples please) to

OEBAC
Disability Department
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

SCAN both sides of this form and of any attachments and EMAIL all to

disability@oebac.org

or

FAX this form and any attachments (both sides if required) to

1-905-469-9066