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.

CITY	PROV.	POSTAL CODE

PHONE NUMBER	NAME OF SPOUSE
( ) -	

IS SPOUSE A S.I.U. MEMBER?	IF SO, UNION NO.:

NAMES OF DEPENDENT CHILDREN	AGE	D	M	Y

DID ACCIDENT OR SICKNESS OCCUR ABOARD SHIP? YES ☐ NO ☐

IF WORK ACCIDENT, WAS SAME REPORTED TO THE COMPANY, CAPTAIN OR OFFICER-IN-CHARGE? YES ☐ NO ☐

IF NOT, WHY?

DID YOU APPLY FOR BENEFITS FROM THE UNEMPLOYMENT INSURANCE COMMISSION? YES ☐ NO ☐

DO YOU WISH TO APPLY FOR SHORT TERM WAGE LOSS BENEFITS? YES ☐ NO ☐

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 _____ CERTIFIED SPECIALIST? _____
(PRINT OR TYPE PLEASE)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE.

DATE _____ 199____ SIGNATURE _____

ADDRESS _____
STREET CITY PROVINCE POSTAL CODE