SEAFARERS' MEDICAL PLAN
200 – 3131 Pitfield Blvd.
Saint-Laurent, QC H4S 1N3
Tel: (514) 931-7859 Ext 227

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 ☐ NO ☐	
CITY	PROV.	POSTAL CODE			IF WORK ACCIDENT, WAS SAME REPORTED TO THE COMPANY, CAPTAIN OR OFFICER-IN-CHARGE? YES ☐ NO ☐	
PHONE NUMBER ( ) -	NAME OF SPOUSE				IF NOT, WHY?	
IS SPOUSE A S.I.U. MEMBER?	IF SO, UNION NO.:				DID YOU APPLY FOR BENEFITS FROM THE UNEMPLOYMENT INSURANCE COMMISSION? YES ☐ NO ☐	

NAMES OF DEPENDENT CHILDREN	AGE	D	M	Y

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