LiUNA!care LOCAL 183
BUILDING HEALTHY FUTURES

DISABILITY SELF PAY EXTENSION FORM

Send to: LiUNAcare Local 183 | 1263 Wilson Avenue, Suite 205 | Toronto, ON M3M 3G2
P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

A Member Information (*Please Print*)

Last Name	First Name	Gender ☐ Male	☐ Female
Address		Birth Date (yyyy/mm/dd)	
Town/City	Province	Postal Code	
Union ID **OR** Social Insurance Number (SIN)		Country	
Email Address		Telephone No.	
Marital Status ☐ Married ☐ Common-Law ☐ Single ☐ Separated ☐ Divorced ☐ Widow		Cell No.	

B Claim Information (*Please Print*)

Proof of your W.S.I.B. / L.T.D. / C.P.P. Claim MUST be attached

Claim Type: ☐ W.S.I.B. ☐ L.T.D. ☐ C.P.P.

Claim No.: _____

Are you currently working? ☐ Yes ☐ No

If yes, please provide information below.

Company Name		Address	
Company Phone No.	Postal Code	City	Province

Reasons for not working: _____

_____

_____

C Member Disclosure Authorization

A false or fraudulent statement on this application form will result in the denial of benefits and/or legal action.

***NOTE: Upon approval, benefit coverage will ONLY include the following:**

- **Life and Dependent Life Insurance**
- **Vision Care**
- **Extended Health Care**
- **Prescription Drugs**
- **Emergency Out of Province**

Member Name: _____ Date: _____
(Print Name)

Member Signature: _____ Witness: _____

Please complete, print, sign, and return by fax at 416.240.7488 **OR** email to info@liunacare183.com