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			Date of Birth (yyyy/mm/dd)
Town/ City	Prov.	Postal Code	Country
Member Advantage Benefit Card ID Number (last 10 digits)			*Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID*
Email Address			Phone #
Marital Status	Married / Common-Law	Single / Separated / Divorced / Widow	Cell #

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: ______________________________

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C Member Disclosure Authorization

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

***<u>NOTE</u>: Upon approval, benefit coverage will <u>NOT</u> include the following:**

- **Short-Term & Long-Term Disability**
- **Permanent and Total Disability Accident**
- **Long Term Care**
- **Hospital Cash**
- **Accidental Death & Dismemberment**
- **Occupational Death & Dismemberment**
- **Special Needs Life Insurance**
- **Critical Illness**
- **Bereavement Pay**
- **Parental Leave**
- **Jury Duty**

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