INCOME REPLACEMENT BENEFITS CLAIM FORM
CLAIMANT STATEMENT
(TO BE COMPLETED BY CAEA MEMBER)

Crawford & Company (Canada)
100 Milverton Blvd - Suite 300
Mississauga, Ontario L5R4H1
O +1-888-688-4344
equity@crawco.ca

CAEA Member No.:

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Legal Name of Claimant:		**Date of Birth:**
Address:		
City:	**Province:**	**Postal Code:**
Phone #: ( )	**Email Address:**	

Briefly describe the role and/or duties including physical requirements:
(include any changes made to the role to accoommodate your injury/sickness)

AUTHORIZATION AND DECLARATION

I, the undersigned, hereby make claim for benefits under my employer's benefit plan adjudicated by Crawford & Company (Canada) Inc. I understand that any information provided to Crawford & Company (Canada) Inc., or their respective authorized agents, will be used in the initial adjudication and determination of my eligibility for benefits, claim and care coordination provisions under the terms of the policy, and potential entitlement to any extension of benefits under this claim.

I DECLARE that the statements provided by me in this authorization and declaration are true and complete, and given of my own free will.

I ACKNOWLEDGE that any person who knowingly files a statement of claim containing materially false, incomplete, or misleading information, or conceals any material facts with intent to defraud or deceive, may be guilty of a fraudulent act subject to civil or criminal penalties, and may be denied benefits related to their claim.

I AGREE that a reproduction of this authorization is as valid as the original.

Claimant Signature _____ Date _____

MEDICAL ATTENTION STATEMENT FORM

(TO BE COMPLETED BY CAEA MEMBER)

Name of Attending Physician:	**Date of first medical attention:**
Physician's Address (Street, City, Province, Postal Code):	
Phone Number: ( )	
If hospitalized, name of hospital:	
Date you were hospitalized: From:	**To:**
If disabled, the date you were first unable to work because of this disability:	☐ **AM** ☐ **PM**
If you returned to work, the date you returned:	☐ **AM** ☐ **PM**
If this was an accident, the date of the accident:	
Did the accident happen at work while under contract? ☐ **Yes** ☐ **No**	
How did it happen?	

DETAILS OF THE ACCIDENT/ILLNESS – TO BE COMPLETED BY EQUITY ENGAGER		
Full Name of Engager:		
Address:		
City:	**Province:**	**Postal Code:**
Phone #: ( )	**Fax #: ( )**	
Members Name:	**Name of Production:**	
On what date did he/she cease work entirely?		
On what date did he/she resume any part of his/her work?		
Provide details of any changes made to the role to accommodate your injury/sickness.		

Signature of Engager: _____ Date Signed: _____

AN ATTENDING PHYSICIAN'S STATEMENT MUST ALSO BE SUBMITTED WITH THIS COMPLETED FORM.

SUBMIT THIS FORM WITH REQUIRED ATTACHMENTS TO:

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Canadian Actors' EQUITY Association