IUOE Local 793

Dismemberment Benefit

Pension and Benefits
Administered by OEBAC

A Introduction

This benefit covers ONLY the Plan Member who had benefit coverage at the time of the incident and who suffered a dismemberment or loss within 365 days of an accident that occurred any time of the day, on or off the job.

➔ To make this application valid, you will need to attach a letter of a physician with details of the medical condition and disability.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of any changes in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B Plan Member's information

For office use only
ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

C Information about the accident

For office use only
ABCDEFGH

Was this accident work-related? ☐ Yes ☐ No

Consequence of the accident (check all that apply):

- ☐ Loss of one hand or both hands
- ☐ Loss of one hand and one foot
- ☐ Loss of sight of one eye
- ☐ Loss of one or more fingers or toes (specify number)
- ☐ Loss of one foot or both feet
- ☐ Loss of sight of both eyes
- ☐ Loss of speech or hearing
- ☐ Paralysis (quadriplegia, paraplegia, or hemiplegia)

Was the accident caused by any of these situations? ☐ Yes ☐ No

- ☐ Attempted suicide, while sane or insane
- ☐ Self-inflicted injuries, while sane or insane
- ☐ Service in the armed forces of any country
- ☐ War, whether or not war was declared
- ☐ Illness or disease

Please provide details of the accident (including, if applicable, the work you were doing at the time):

By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of Plan Member	Signature of Plan Member	Date (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to

info@oebac.org