APPLICATION FOR SICK PAY BENEFITS

INSTRUCTIONS: To be accepted, your claim must be submitted to the Administrator no later than 45 days after your first day off due to illness or injury. Payment will not be made for partial days missed.

Step 1: answer all questions and sign the reverse side of this form
Step 2: complete your Section of the attached "Employer/Attending Physician's Statement", then have your employer complete the "Employer's Section"
Step 3: take the form to your Physician for completion
Step 4: mail both forms to the Administrator.

This claim will be returned to you if it is incomplete or contains errors.

Please see reverse side for Certification and Consent

CLAIMANT INFORMATION

Name _____ S.I.N._____
(Last) (First)

Address _____
(Number and Street) (City) (Province) (Postal Code)

Phone Number _____ Clock Number _____

My regularly scheduled days of work are: ☐ Monday to Friday ☐ Other _____

Shift: ☐ Day ☐ Evening ☐ Midnight Number of hours per shift _____

DISABILITY

I was absent from employment on the following scheduled working day(s): _____

_____

Is illness or injury work-related? ☐ No

☐ Yes. If "Yes" have you filed a claim with Workers' Compensation? ☐ Yes ☐ No

If an injury was sustained, describe when, where and how injury occurred (include police report number and MPIC claim number, if applicable)

Describe the specific symptoms which prevent you from performing your Regular Job Duties:

On the day you stopped working as a result of your illness/injury, were you employed in any other occupation other than your position at Western Glove? ☐ Yes ☐ No

OTHER INCOME (indicate if you are entitled to benefits for the days missed from any of the following)

Source	Yes	No	Date Application Submitted	Date Benefits Commenced	Date Benefits Ceased
Worker's Compensation					
Employment Insurance					
Canada Pension Plan					
Social Assistance					
Other (Specify) _____					

AUTHORIZATION/CERTIFICATION AND CONSENT

I understand that it is an offense to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete to the best of my knowledge and belief.

I understand that any information obtained by the Plan administrator will not be disclosed to anyone EXCEPT: insurance companies, third party administrators, administrators of government benefits, physicians, rehabilitation professionals, vocational evaluators, and any institution or person, on a need to know basis, for the purpose of verifying and/or evaluating benefit entitlements or as may be necessary to prevent or to detect the perpetration of a fraud.

I authorize the Plan administrator to release any and all of the information related to this claim to the Board of Trustees or to my employer, in confidence, when required to resolve my entitlement to benefits.

I authorize the use of my Social Insurance Number, to satisfy the government's reporting requirements and as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that my personal information, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; determine future operating costs; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy my personal information. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review this information to ensure that it is up-to-date and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be cancelled.

This authorization is valid for the duration of my claim.

A photostatic copy of this authorization will be as valid as the original.

_____ _____

Signature of Claimant Date

_____ _____

Signature (if other than Claimant) Date

THE TRUSTEES RESERVE THE RIGHT TO DENY OR TERMINATE BENEFITS AND RECOVER ANY PAYMENTS MADE FOR FAILURE TO DISCLOSE ALL RELEVANT INFORMATION

Return this form to:
UFCW Local 832 Benefit Plan (Apparel Division)
3rd Floor, 880 Portage Avenue Winnipeg, Manitoba R3G 0P1

APPLICATION FOR SICK PAY BENEFITS
EMPLOYER'S/ATTENDING PHYSICIAN'S STATEMENT

PART 1 - CLAIMANT AUTHORIZATION

Name _____ Clock Number
(Last Name) (First Name)

Address
(Number and Street) (City) (Province) (Postal Code)

I authorize any licensed physician, health care practitioner, hospital, clinic, institution, or other medical or medically related facility, insurance company or similar entity, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or person, that has any record or knowledge of me or my health to release to the Plan administrator:

(a) Any requested medical information regarding my physical or mental condition. For purposes of this authorization, medical information includes confidential information regarding alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.
(b) Work information, including but not limited to, job duties and earnings.
(c) Information concerning government benefits, including but not limited to, monthly benefit amounts and entitlement dates.

Signature of Claimant _____ Date

Signature (if other than Claimant) _____ Date

PART 2 - EMPLOYER'S STATEMENT (TO BE COMPLETED BY THE EMPLOYER)

The Claimant was absent from work on the following scheduled working days

Date _____ Signature of Employer

PART 3 - PHYSICIAN'S STATEMENT (TO BE COMPLETED BY PHYSICIAN)

Primary Diagnosis _____

Date Claimant first visited you regarding the illness/injury pertaining to this claim _____

Date of last visit _____

If Hospitalized for this illness or injury, name of Hospital _____

*Note: "Hospitalized" means admitted to a ward or if no ward room available issued a bed. Also includes day surgery.

Date Admitted _____ Date Discharged _____

Date of surgery (if applicable) _____

Describe how the illness/injury prevents the Claimant from performing his/her Regular Job Duties:

_____

_____

Is the illness or injury arising out of the Claimant's employment? ☐ Yes ☐ No

Date Claimant can return to work _____

Name of Attending Physician (Please Print) _____

Address _____
(Street) (City) (Province) (Postal Code)

Signature of Physician _____ Date _____

PLEASE ENSURE THAT YOU HAVE ANSWERED ALL QUESTIONS AND PROVIDED COMMENTS WHERE REQUESTED

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