# VANTAGE FOODS (MB)/UFCW BENEFIT PLAN

## SICK PAY CLAIM FORM

**IMPORTANT: 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 shift absences. Please answer all questions and sign the reverse side of this form. This claim will be returned to you if it is incomplete or contains errors.**

**Please see reverse side for instructions on completion and Certification and Consent**

## SECTION 1 - MEMBER'S STATEMENT

Member's Name _____ SIN _____

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

Phone Number _____

**I hereby certify that I was absent from employment due to (please "X" one) : ☐ illness ☐ injury on the following scheduled working day(s):**

| Date | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hrs. Scheduled | | | | | | | |
| Hrs. Worked | | | | | | | |
| | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |

**If absence is due to an injury, was this injury due to a motor vehicle accident? ☐ Yes ☐ No**

**If the injury is work related, has a claim been made to Workers' Compensation? ☐ Yes ☐ No**

***Any Employee making a false claim will be required to repay any monies paid by the Trust Fund and may have future eligibility discontinued by the Trustees.***

## SECTION 2 - EMPLOYER VERIFICATION

Job Classification _____

(a) I hereby verify that the above-named Employee was absent from employment due to illness or injury on the following scheduled working day(s):

| Date | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hrs. Scheduled | | | | | | | |
| Hrs. Worked | | | | | | | |
| | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |

(b) Is the illness or injury work related? ☐ No ☐ Yes

If "Yes" has a claim been made to Workers' Compensation? ☐ Yes ☐ No

If "No" why not? _____

_____ _____
Date Management's Name (Please Print)

_____
Management's Signature

Please complete and return this form to:
**VANTAGE FOODS (MB)/UFCW BENEFIT PLAN**
3rd Floor, 880 Portage Avenue Winnipeg, Manitoba R3G 0P1

## INSTRUCTIONS ON COMPLETING THE FORM

**1. Make sure that you complete all of Section 1 of the form as follows:**

## SECTION 1 - MEMBER'S STATEMENT

Member's Name *Fred Smith* SIN *123-456-789*

Address *123 Anywhere Avenue* *Winnipeg* *Manitoba* *R0R 0R0*
(Number and Street) (City) (Province) (Postal Code)

Phone Number *555-5555*

I hereby certify that I was absent from employment due to (please "X" one) : ☒ illness ☐ injury
on the following scheduled working day(s):

| Date | | *January 6* | *January 7* | | | | |
|---|---|---|---|---|---|---|---|
| Hrs. Scheduled | | *6.0* | *5.0* | | | | |
| Hrs. Worked | | *0.0* | *0.0* | | | | |
| | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |

If absence is due to an injury, was this injury due to a motor vehicle accident? ☐ Yes ☒ No

If the injury is work related, has a claim been made to Workers' Compensation? ☐ Yes ☒ No

**2. After you have completed Section 1, give the form to your Manager, or designate, to complete Section 2.**

**3. After Section 2 has been completed and the form has been returned to you, mail the form as soon as possible to the Administrator at the address at the bottom of the form.**

## 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 and complete.

I authorize the use of my Social Insurance Number 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.

If I have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, in order to determine coverage and benefit entitlement.

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

_____ _____
Signature of Member Date