UFCW LOCAL 832 BUS DRIVERS' SICK LEAVE/HEALTH BENEFIT PLAN

SICK LEAVE CLAIM FORM

IMPORTANT: To be accepted, your claim must be submitted to the Plan Administrator no later than 45 days after your first day off due to illness or injury. Please answer all questions. 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 ______________________________
(First) (Last)

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

Phone Number ______________________________

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

Date of Absence					
Regular Run a.m.					
Noon Run					
Regular Run p.m.					

If you were off because of an injury, describe when, where and how the injury occurred (include police report number and MPIC claim number, if applicable) ______________________________

____

Is the illness/injury work related? ☐ **Yes** ☐ **No**
If "Yes" has a claim been made to Workers' Compensation? ☐ **Yes** ☐ **No**

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE. I UNDERSTAND THAT MAKING A FALSE CLAIM MAY RESULT IN HAVING MY MEMBERSHIP IN THE PLAN DISCONTINUED. I AM AWARE OF AND HAVE READ THE "CERTIFICATION AND CONSENT" ON THE REVERSE SIDE OF THIS FORM.

______________________________ ______________________________
Signature of Member Date

SECTION 2 - EMPLOYER VERIFICATION

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

Date of Absence					
Regular Run a.m.					
Noon Run					
Regular Run p.m.					
Total Lost Wages					

______________________________ ______________________________
Date Supervisor's Signature

Please complete and return this form to:
UFCW LOCAL 832 BUS DRIVERS' SICK LEAVE/HEALTH BENEFIT PLAN
3rd Floor, 880 Portage Avenue Winnipeg, Manitoba R3G 0P1
Phone: 982-6087 (in Winnipeg) 1-877-982-6087 (outside Winnipeg) ▪ Fax: 982-6080

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 (EXAMPLE)

Member's Name *Fred Smith*

Address *123 Anywhere Avenue* (Number and Street) *Winnipeg* (City) *Manitoba* (Province) *R0R 0R0* (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 of Absence	October 17	October 18			
Regular Run a.m.		X			
Noon Run		X			
Regular Run p.m.	X				

If you were off because of an injury, describe when, where and how the injury occurred (include police report number and MPIC claim number, if applicable) ____

Is the illness/injury work related? ☐ Yes ☒ No

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

2. After you have completed Section 1, give the form to your Supervisor to complete Section 2.

3. After Section 2 has been completed, mail or Fax the form to the Plan Administrator as soon as possible.

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 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: communicate with me; determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; 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 impaired or 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.