HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN

3rd Floor, 880 Portage Avenue Winnipeg, Manitoba R3G 0P1

APPLICATION FOR SICK PAY BENEFITS - CLAIMANT'S STATEMENT

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. Please answer all questions and sign the reverse side of this form. This form will be returned to you if it is incomplete or contains errors. After you have completed this form, take the Attending Physician's Statement to your doctor for completion. Once completed mail both forms to the Administrator.

Please see reverse side for Certification and Consent

Name ______________________________ S.I.N. ____________________
(Last Name) (First Name)

Mailing Address ____

Phone Number ____________________

DISABILITY

Date Illness/Injury Commenced ________________________________

Is the Illness or Injury directly related to or resulting from your employment?

☐ No
☐ Yes. If "Yes" has a claim been filed with Workers' Compensation? ☐ Yes ☐ No

If you are off because of an Injury, 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:

Have you been able to work for salary or profit since the commencement of your present illness/injury?

☐ No
☐ Yes (If "Yes", provide details) ________________________________

Has your doctor told you when you can return to work?

☐ Yes, approximate date ____________________ ☐ No

OTHER INCOME

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 and complete.

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 and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.
(b) Work information and history, 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.

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 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

HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN

APPLICATION FOR SICK PAY BENEFITS - ATTENDING PHYSICIAN'S STATEMENT

DO NOT COMPLETE THIS FORM IF HYLIFE HAS CONFIRMED THE CLAIMANT IS POSITIVE FOR COVID

PART 1 - CLAIMANT AUTHORIZATION (TO BE COMPLETED BY MEMBER)

Mr. ☐ Name ______________________________ SIN ______________________
Ms. ☐ (First) (Last)

Mailing Address ____

Phone Number ______________________

I hereby authorize the release of any information requested with respect to my claim for benefits.

Signature of Claimant ______________________ Date ______________

Signature (if other than Claimant) ______________________ Date ______________

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

Primary Diagnosis ____

Date Claimant first visited you regarding this Illness/Injury ______________________

Date of last visit ____

Describe how the Illness/Injury prevents the Claimant from performing his/her Regular Job Duties:

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____

Date Claimant can return to work ______________________

Is the Illness or Injury directly related to or resulting from the Claimant's employment?

☐ No
☐ Yes. If "Yes" has a claim been filed with Workers' Compensation? ☐ Yes ☐ No

Is the injury the result of a Motor Vehicle Accident? ☐ Yes ☐ No ☐ Unknown

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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

If you have any questions please call the Administrator toll free at 1-877-982-4171.

Please submit this form when fully completed to:
HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1