MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN
SICK BENEFIT 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 or for any day for which any payment has been made through the Company Sick Credit Plan. Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

ANY EMPLOYEE MAKING A FALSE CLAIM WILL BE REQUIRED TO REPAY ANY MONIES PAID BY THE PLAN AND MAY HAVE FUTURE ELIGIBILITY DISCONTINUED BY THE TRUSTEES.

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

SECTION 1 - MEMBER'S STATEMENT

Member's Name _____ SIN _____
(First) (Last)

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

Phone Number _____

EMPLOYER: ☐ **SAFEWAY** ☐ **CO-OP** ☐ **CANADA BREAD** ☐ **AGROPUR** ☐ **CMS**

I HEREBY CERTIFY THAT I WAS ABSENT FROM EMPLOYMENT DUE TO: ☐ **ILLNESS** ☐ **INJURY**
ON THE FOLLOWING SCHEDULED WORKING DAY(S):

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

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

_____

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

Were you hospitalized at any time during the first 3 three days following the onset of your illness or injury? If Yes, please provide details:

_____

_____

I CERTIFY THAT 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'S STATEMENT

I hereby verify that the above named Employee was absent from employment as stated above. The following hours were paid to the Employee through the Company Sick Credit Plan:

CURRENT HOURLY WAGE RATE:_____

Date							
Hours Paid							
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

_____ _____
Date Store/Plant Manager's Signature

Please complete and return this form to:
MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN
DA Townley, 4250 Canada Way Burnaby, BC V5G 4W6
Email: ufcwadmin@datownley.com Phone: 604-299-7482 Toll Free: 1- 800-663-1356

MEMBER 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* (Number and Street) *Winnipeg* (City) *Manitoba* (Province) *R0R 0R0* (Postal Code)

Phone Number *204-555-5555*

EMPLOYER: ☒ **SOBEYS** ☐ **CO-OP** ☐ **CANADA BREAD** ☐ **AGROPUR** ☐ **CMS**

I HEREBY CERTIFY THAT I WAS ABSENT FROM EMPLOYMENT DUE TO: ☐ **ILLNESS** ☒ **INJURY**
ON THE FOLLOWING SCHEDULED WORKING DAY(S):

Date			May 19	May 20			
Hrs. Scheduled			6.0	5.0			
Hrs. Worked			0.0	0.0			
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

If you were off because of an injury, describe when, where and how the injury occurred (include police report number and MPI claim number, if applicable) *fell off of a ladder while painting my house on May 18 and sprained my ankle*

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

Were you hospitalized at any time during the first 3 three days following the onset of your illness or injury? If Yes, please provide details:

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE "CERTIFICATION AND CONSENT" ON THE REVERSE SIDE OF THIS FORM.

Fred Smith Signature of Member **June 4, 2015** Date

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