LEAVE OF ABSENCE / COVID-19-RELATED LEAVE FORM
UFCW LOCAL 401 DENTAL CARE PLAN

YOUR COMPLETED FORM MUST BE RECEIVED BY THE ADMINISTRATOR WITHIN 12 WEEKS OF THE DATE YOUR ABSENCE COMMENCED

Please Print:

Employee First Name _____ Employee Last Name _____ SIN or Certificate Number. _____

Complete Mailing Address _____

City _____ Province _____ Postal Code _____ Phone Number _____

Date Your Absence Commenced _____ Expected Date of Return _____

To Be Completed By The Manager/Supervisor:

Company _____ Store Number, Store Name, or Geographic Location _____ Employee's Position/Department _____

The Employee named above was/is absent from work for the following reason(s):

- ☐ Covid-19 Related Absence*
- ☐ Occupational Illness/injury
- ☐ Maternity/Parental Leave (Child's Date of Birth or adoption) _____
  A copy of the child's birth certificate must accompany this Form
- ☐ Compassionate or other Leave (please specify) _____
- ☐ Vacation
- ☐ Non-Occupational Illness/injury

Name of Manager/Supervisor _____ Telephone Contact Number _____

Manager/Supervisor's Signature _____ Date Signed _____

*For more information about the **Canada Recovery Sickness Benefit**, **Canada Recovery Caregiving Benefit**, or other COVID-19 government sponsored programs, please go to: https://www.canada.ca/en/department-finance/economic-response-plan.html

NOTE – Please provide documentation if your doctor recommends a return-to-work/modified duties plan resulting in worked hours below the minimum number required to qualify for the Plan. That will ensure your benefits do not lapse while on modified duties.

RETURN YOUR COMPLETED FORM TO: PBAS (THE ADMINISTRATOR)
SUITE 101, 46 HOPEWELL WAY NE
CALGARY, ALBERTA T3J 5H7
Toll-free: 1-866-961-6147 Email: calgary@pbas.ca
Fax: 1-403-250-9236

To Be Signed By The Employee:

I hereby certify that the above information is true, correct and complete, and I have not engaged in any occupation or employment since my absence commenced.

Date Signed _____ Employee Signature _____

Eligibility Rules

To be eligible for participation in the Plan you must be an employee of a participating employer, and a Member of UFCW Local 401. To be eligible for claims reimbursement you must have worked five (5) consecutive months and at least 120 hours in the last 12 consecutive week period reported to the Administrator. Coverage starts the first of the month following the above-noted requirements.

Entitlement continues, provided you work an average of ten (10) hours per week during the most recently reported twelve (12) consecutive week period.

Your participation in the Plan terminates on your employment termination date, the date the Plan terminates, or as otherwise provided below.

Your dependents are covered, including your spouse, and your unmarried children under the age of 21 (or under the age of 25 while attending an accredited education institution). Coverage will continue beyond the maximum ages indicated above for a child who is incapable of self-sustaining employment because of a mental or physical impairment. The Member must provide satisfactory proof to the Administrator that the dependent is not capable of self-support.