

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
(First) (Last)

Address 123 Anywhere Avenue SE Calgary Alberta
T1V 1V1
(Number and Street) (City) (Province) (Postal Code)

Phone Number 587-589-5678

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

Date		June 6	June 7				
Hours Scheduled		6.0	5.0				
Hours Worked		0.0	0.0				
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Is the illness/injury work related? Yes No

If "Yes" has a claim been made to Worker's Compensation? Yes No Not Applicable

2. After you have completed and signed Section 1, give the form to your Store Manager to complete and sign Section 2.
3. After Section 2 has been completed and signed 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 page 1 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 scan or photocopy of this authorization will be as valid as the original.