UFCW – CANADA SAFEWAY LIMITED
PART-TIME EMPLOYEE BENEFIT PLAN

SICK DAY CLAIM FORM

IMPORTANT: To be accepted, your claim must be submitted to the Administrator no later than 60 days after your first day off due to illness or injury. Payment will not be made for partial shift absences. Please answer all questions and sign the form. 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 Trust Fund 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 _____

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

Date							
Hrs. Scheduled							
Hrs. Worked							
	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

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 VERIFICATION

Store Name/Number _____ Hourly Wage Rate _____

I hereby verify that the above-named Employee was absent from employment due to illness or injury on the dates noted above:

_____ _____ _____
Date Store Manager or his/her Designate Signature Name and Position (please print)

For every 300 hours credited to your hour bank, you are entitled to claim one paid sick day. You can accumulate a maximum of 1800 hours (6 sick days) in your hour bank. The amount of your sick day benefit is based on your hourly wage. Your sick day benefit is a flat amount, paid for each full shift missed.

Hourly Wage	**Sick Day Benefit**
Less than $14	$60 per sick day
$14 to $18	$75 per sick day
More than $18	$90 per sick day

Please complete and return this form to:
UFCW – CANADA SAFEWAY LIMITED PART–TIME EMPLOYEE BENEFIT PLAN
Suite 101, 46 Hopewell Way N.E., Calgary, Alberta T3J 5H7
Tel: (403) 250-3534 or 1-866-544-9686 Fax: (403) 250-9236

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

If an injury was sustained, describe when, where and how injury occurred: *June 5, fell down stairs at home, broken toe*

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

If "Yes" has a claim been made to Worker's Compensation? ☐ Yes ☐ No

2. After you have completed and signed Section 1, give the form to your Manager or Supervisor 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 photocopy or electronic copy of this authorization will be as valid as the original.