UFCW LOCAL 401 DENTAL CARE PLAN
GROUP 13901
SUITE 101, 46 HOPEWELL WAY NE, CALGARY, ALBERTA T3J 5H7
TELEPHONE: (403) 250-3534 TOLL-FREE: 1-866-961-6147 FAX: (403) 250-9236

Notification Re: Absence from Work*

Please Print:

First Name _____ Last Name _____ S.I.N. _____

Complete Mailing Address _____

City _____ Province _____ Postal Code _____ Phone Number _____

To be completed by the Employer:

Date Absence Commenced _____ Expected Date of Return _____

This is to certify that the above named employee has been/will be absent from work for the following reason(s):

- ❑ on the job illness or injury **
- ❑ non-occupational injury/illness **
- ❑ maternity/parental leave Expected Date of Birth of Child _____
- ❑ other (please specify) _____

Name of Employer _____ Telephone Contact _____

Authorized Signature _____ Date _____

*See the Plan Eligibility Rules on the reverse.

**Include satisfactory proof of your illness or injury, dates you will be absent from work and a copy of proposed schedule or the previous week's schedule to verify your standard hours of work.

NOTE – Please provide documentation if your doctor allows you to work below 10 hours per week to qualify for the plan. This will ensure that your benefits will not lapse while on modified duties.

To be completed by the Member:

I hereby certify that I have not engaged in any occupation or employment since my absence commenced.

Date _____ 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 dependants 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 dependant is not capable of self-support.