

UNITE HERE HEALTH & WELFARE PLAN

Administered by

SoBen Ltd.

150 Consumers Road, Suite 302, Toronto, Ontario M2J 1P9

Tel: 416-498-8338 Toll Free: 1-888-887-6879 Fax: 416-498-4591

ACCIDENT & SICKNESS, MATERNITY/PARENTAL CLAIM FORM

(Must be submitted within 90 days of last day worked)

Member's Section: (To be filled out by the employee)

Last Name: _____ First Name: _____ Male Female

Address: _____ Apt. No.: _____ S.I.N. No.: _____

City: _____ Province: _____ Postal Code: _____ Home Tel.: _____

Date of disability:

day	month	year

Date of Birth:

day	month	year

If an accident, where did it occur? Home Work Elsewhere: _____

Cause of disability: _____

I hereby certify that the above information is true. I authorize any medical practitioner, hospital, employer, UNITE HERE Local 75, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare and Pension Plans and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

Date: _____ Department: _____ Signature: _____

Please inform Soben Ltd. as soon as you return to work.

Employer's Section: (To be filled out by the employer)

Place of Employment: _____ Tel.: _____

Employment Address: _____

Reason for absence: _____

Was this an accident? yes no Is this a W.S.I.B. case? yes no

Do you consider the disability to be the result of: a) Intentionally self-inflicted sickness or injury? yes no
b) Pregnancy? yes no

Did disability occur during employee's vacation? yes no

If yes, specify vacation period: _____

Last day worked:

day	month	year

Hourly rate of Pay: \$ _____ / hr.

Date returned or expected to return to work:

day	month	year

Regular days off: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.
Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

(if irregular indicate days off for sickness period)

Date: _____ Position: _____ Signature: _____

