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

COMPASSIONATE CARE & PARENTS OF CRITICALLY ILL CHILDREN 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.: ______________

Commencement of Leave:

day	month	year

Date of Birth:

day	month	year

Effective Date of Employment Insurance (E.I.) coverage: ______________________

(**Provide a copy of your letter from E.I. confirming the start and end date of your benefit and a copy of your first E.I statement showing the period and amount paid**)

Ill Family Member Section: (To be filled out by the employee)

Last Name: ______________________ First Name: ______________________

Relationship to the Member: ______________________ Date of Birth:

day	month	year

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: ____

Did this leave 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

Date: ________________ Position: __________________ Signature: ______________________