

UNITE HERE HEALTH & WELFARE PLAN

Administered by

Soben Management 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)

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

Last Name: _____ First Name: _____

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

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

Commencement of Leave:

day	month	year
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 Date of Birth:

day	month	year
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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
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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 Management 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
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Hourly rate of Pay: \$ _____ / hr.

Date returned or expected to return to work:

day	month	year
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Date: _____ Position: _____ Signature: _____