NO FRILLS/UFCW BENEFIT TRUST FUND
APPLICATION FOR SUPPLEMENTARY HOURS CREDIT

NO FRILLS/UFCW
BENEFIT TRUST FUND

MEMBER'S STATEMENT OF CLAIM

Employer:		Employer Location (City/Province)		
Member Name:		Member Address: Telephone Number:		
Social Insurance Number:	Date of Birth:	Gender: ■ Male ☐ Female	Date Employed:	Date Last worked:
Is absence due to illness/injury or jury duty?		Loss of time commenced:	Date returned to work:	

**** IF ABSENCE IS DUE TO JURY DUTY, ATTACH A COPY OF THE REQUEST TO ATTEND NOTICE TO THIS FORM ****
**** IF ABSENCE IS DUE TO COMPASSIONATE CARE LEAVE PROOF OF APPROVAL OF AN E.I. CLAIM MUST BE SUBMITTED AND YOUR EMPLOYER MUST ALSO VERIFY THE LEAVE. THE PLAN COVERS COMPASSIONATE CARE LEAVE TO A MAXIMUM OF 3 MONTHS. ALL OTHER PROVISIONS IN THIS REGARD FOLLOW THE EMPLOYMENT INSURANCE ("E.I.") REGULATIONS. ****

I hereby authorize the Administrator to use my Social Insurance Number for purposes of administration of my group benefit plan. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the purpose herein.

Signature of Member _____ Date _____ Witness _____

IN CASE OF ACCIDENT - COMPLETE THE FOLLOWING

Date and Time of Accident: Day: Month: Year: ■ AM ☐ PM	Where did accident occur? (i.e. Home, Business, Other - Specify)
How did accident occur?	What was the employee doing at the time of the accident?
Nature of injuries - (Specify)	

EMPLOYER'S STATEMENT

Date Last Worked:	Reason for Absence: Companionate Care Leave ■ Maternity Leave ☐ Jury Duty ☐ Illness ☐ Injury ☐
Expected/Return to Work Date:	Comments:
Authorized Signature:	Name (please Print):
Title:	Date:

See Reverse for Physician's Statement

PHYSICIAN'S STATEMENT (TO BE COMPLETED IF ABSENCE IS DUE TO ILLNESS/INJURY)

1. Patient's Name: Age:

2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

3. Diagnosis of Present Condition: Secondary if Applicable:

4. To the best of my knowledge, symptoms first appeared or accident happened:
Patient has had the same or similar condition: ☐ Yes ☐ No ☐ Unknown

5. Date of hospital in-patient admission: Date of discharge:

6. If Surgery performed, describe:
Date:

7. If referred to you, give name of referring physician:

8. Date of first visit for present period of disability: Month:_____ Day:_____ Year:_____
Date of latest attendance: Month:_____ Day:_____ Year:_____
Were you actively supervising this patient's care during the full period? ☐ Yes ☐ No If yes, indicate weekly, monthly, other

9. If condition is due to pregnancy, what is/was the expected date of confinement:

10. To the best of my knowledge, the patient has been Totally Disabled (unable to work) from: _____ to: _____
If still disabled, give approximate date when patient should be able to return to work: _____

11. How long was or will patient be Partially Disabled (able to work modified hours/duties at own occupation)?

12. How does present condition affect patient's ability to work?

Physician's Name (Print): Address:

Telephone No. Signature: Date:

I authorize the release of the information contained in this form to the Administrator for purposes of administration of my group benefit plan.
Date: _____ **Signature of Patient:** _____

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION

Mail Form to: **110-61 International Blvd., Toronto, Ontario M9W 6K4**
(416) 674-3350/ 1(800) 461-4361
Fax: (416) 674-1525

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