UNIFOR Local 112 Health & Welfare Plan

Claim Form for Maternity, Parental and Compassionate Care Leave Top Up Benefits

Please PRINT clearly in ink, sign and date the form, and return to the Plan Administration Office **within 90 days of last day worked.**

Notice to Employee: If your benefits are taxable, Income Tax will be deducted from your benefit payments. Direct deposit may be available – contact the Plan Administration Office at questions@millworkersuniforbenefits.org

1. MEMBER'S SECTION – to be completed by the EMPLOYEE

Member's Last Name	**Member's First Name**		**Social Insurance Number**	
Address (street number and name)		**Apt. Number**	**Phone Number**	
City	**Province**	**Postal Code**	Gender	**Date of Birth** (YYYY-MM-DD)
Type of Leave ☐ Maternity ☐ Parental ☐ Compassionate Care	**Date Leave Commenced** (YYYY-MM-DD)	**Effective Date of Employment Insurance Benefits** (YYYY-MM-DD)		

FOR COMPASSIONATE CARE LEAVE ONLY – Provide Information on Family Member under Care

Family Member Last Name	**Family Member First Name**	**Family Member Date of Birth** (YYYY-MM-DD)
Relationship to Member	**Nature of Disability**	

I authorize the Millworkers Health & Welfare and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial,health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.

Employee Signature (This must be signed before claim can be assessed.)	**Date Signed** (YYYY-MM-DD)

Along with this form you must provide a copy of documentation from Employment Insurance (E.I.) confirming the start date, end date and weekly amount of your E.I. payments

2. EMPLOYER'S SECTION – to be completed by the EMPLOYER

Name of Employer		**Phone Number**
Address		
Type of Leave ☐ Maternity ☐ Parental ☐ Compassionate Care	**Date last worked:** (YYYY-MM-DD)	**Date returned or expected to return to work** (YYYY-MM-DD)
Occupation		**Current Hourly Rate of pay** **$** **per hour**
Remarks		

Signed (employer's representative)	**Date Signed**(YYYY-MM-DD)	**Contact Email**

PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATION OFFICE

45 McINTOSH DRIVE, MARKHAM, ON L3R 8C7
Phone: 1-800-263-3564 Fax: 905-946-2535
email:questions@millworkersuniforbenefits.org