

UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

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APPLICATION FOR DISABILITY BENEFITS EMPLOYER'S STATEMENT

PART 1 - CLAIMANT INFORMATION

Name _____ SIN _____
(First) (Last)

Employee Number _____ Date of Birth _____

Address _____
(Number and Street) (City) (Province) (Postal Code)

PART 2 - EMPLOYER'S STATEMENT

Date of Hire _____ Last regularly scheduled day worked _____

First regularly scheduled day absent from work due to present Disability _____

Employment Status on date of Disability:

- (a) Full-Time Part-Time
- (b) At Work Leave Of Absence Layoff Maternity/Parental Leave
 Jury Duty Vacation Terminated Strike/Lockout

Basic Rate of Pay per hour _____ Regularly Scheduled Hours per week _____

Regularly Scheduled Days per week Monday to Friday Sunday to Thursday Other _____

Personal Tax Credits Return (TD1 E) Claim Code _____

Is Disability arising out of Claimant's employment? Yes No

Has Claimant returned to work?

- No
 Yes. If Yes, date returned to work _____

Additional comments _____

Signature of Employer _____ Date _____