UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba R3G 0P1
Phone: 204-982-4170 • 1-877-982-4170
Fax: 204-982-6080

AGREEMENT TO REIMBURSE

I, ____ agree to repay the UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN TRUST FUND immediately, if I receive any money from any other source for the same period that disability income is paid to me under the UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN (Benefit Plan) if, such amount has not been taken into account in the calculation of the amount paid by the Benefit Plan.

I also agree that the amount of such reimbursement shall be equal to the difference between the amount that was actually paid by the Benefit Plan and the amount that would have been paid had allowance been made for the amount received by me from such other source.

I also agree that if I fail to reimburse the Benefit Plan, any portion of the amount owing, the Administrator may arrange for the outstanding amount to be deducted from my wages and remitted to the Benefit Plan or may commence legal action against me.

__________________________________ __________________________

SIGNATURE DATE

PLEASE NOTE THAT THE WITNESS MUST SIGN AND DATE THIS FORM ON THE SAME DAY AS YOU

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WITNESS' SIGNATURE DATE