GARDA SECURITY/UFCW LOCAL 1400
SICK PAY BENEFIT PLAN

BENEFIT CLAIM FORM
(Garda Security Members Only)

SECTION 1 – MEMBER CERTIFICATION (PLEASE PRINT)

(See instructions for completion on reverse)

Member's Name _____ SIN _____

Address _____
(Street)

_____
(City) (Province) (Postal Code)

I hereby certify that I was absent from employment due to (please "x" one): ☐ illness ☐ injury

If absence is due to an injury, was this injury due to a motor vehicle accident? ☐ Yes ☐ No

I was absent from employment on the following scheduled working day(s):

Date							
Hrs. Scheduled							
Hrs. Worked							
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

I authorize Coughlin & Associates Ltd. to collect and exchange required personal information about me and/or my dependents to process this claim and administer my group benefit program. I understand any personal information collected by Coughlin & Associates Ltd. will be kept confidential and, where necessary to process this claim and administer my group benefit program, Coughlin & Associates Ltd. may exchange my personal information with the following persons, organizations or parties: any health care practitioners, medical facility or provider of health care/dental services; any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator; my employer of former employer, my local union or benefit plan trustees, government agency, auditing or independent investigative organization, and financial institution.

I certify that the information contained in this form is true and complete to the best of my knowledge.

_____ _____
Date Member's Signature

SECTION 2 – EMPLOYER VERIFICATION (CLAIM FOR SICK PAY ONLY)

Facility No./Location _____ Hourly Wage Rate _____

I hereby verify that the above-named Member was absent from employment due to illness or injury on the following scheduled working day(s):

Date							
Hrs. Scheduled							
Hrs. Worked							
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Is the illness or injury work related?

☐ Yes ☐ No

If Yes, has a claim been made to Workers' Compensation?

☐ Yes ☐ No (If No, why not?)

_____
_____

_____ _____
Date Supervisor's or Manager's Name (Please Print)

_____
Supervisor's or Manager's Signature

Any Member making a false claim will be required to repay any monies paid by the Trust Fund and may have future eligibility discontinued by the Trustees

Please complete and return this form to:

Coughlin & Associates Ltd.
Administrator
P.O. Box 764
Winnipeg, MB R3C 2L4
Phone: (204) 942-4438
Toll Free: 1-800-665-0122
Fax: (204) 943-5998
Email: winnclaim@coughlin.ca

Please Turn Over ➔

INSTRUCTIONS ON COMPLETING THE FORM

- SEE EXAMPLE BELOW -

1. Make sure that you complete all of Section 1 of the form as follows:

SECTION 1 – MEMBER CERTIFICATION (PLEASE PRINT)

Member's Name _____*John Doe*_____ SIN ___*123-456-777*_____

Address _____*777 Anywhere Street*_____
(Street)

_____*Saskatoon*_____ _*Saskatchewan*_ _____*S5S 0M1*_____
(City) (Province) (Postal Code)

I hereby certify that I was absent from employment due to (please "x" one): ☐ illness ☐ injury

If absence is due to an injury, was this injury due to a motor vehicle accident? ☐ Yes ☐ No

I was absent from employment on the following scheduled working day(s):

Date		*June 14*	*June 15*				
Hrs. Scheduled		*6.0*	*5.0*				
Hrs. Worked		*0.0*	*0.0*				
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

_____*July 17, 2002*_____ _*John Doe*_____
Date Member's Signature

After you have completed Section 1, give the form to your Store Manager, or Supervisor, to complete Section 2.

After Section 2 has been completed and the form has been returned to you, mail the form as soon as possible to the Administrator at the address at the bottom of the form

Either a cheque, or information concerning why your claim was unable to be processed, will be mailed to you within 5 working days following receipt of the form by the Administrator.

Important Note
Your claim form must be completed as soon as possible and received by the Administrator no later than 45 days after your first day off due to illness or non work-related injury. Payment will not be made for partial shift absences. You may be required to provide medical evidence for assessment purposes.