

**UNITE HERE HEALTH & WELFARE PLAN**

Administered by

**SoBen Ltd.**

150 Consumers Road, Suite 302, Toronto, Ontario M2J 1P9

Tel: 416-498-8338 Toll Free: 1-888-887-6879 Fax: 416-498-4591

**ACCIDENT & SICKNESS, MATERNITY/PARENTAL CLAIM FORM**

(Must be submitted within 90 days of last day worked)

**Member's Section:** (To be filled out by the employee)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Male  Female

Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ S.I.N. No.: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Tel.: \_\_\_\_\_

Date of disability: 

day	month	year

Date of Birth: 

day	month	year

If an accident, where did it occur? Home  Work  Elsewhere: \_\_\_\_\_

Cause of disability: \_\_\_\_\_

I hereby certify that the above information is true. I authorize any medical practitioner, hospital, employer, UNITE HERE Local 75, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare and Pension Plans and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

Date: \_\_\_\_\_ Department: \_\_\_\_\_ Signature: \_\_\_\_\_

*Please inform Soben Ltd. as soon as you return to work.*

**Employer's Section:** (To be filled out by the employer)

Place of Employment: \_\_\_\_\_ Tel.: \_\_\_\_\_

Employment Address: \_\_\_\_\_

Reason for absence: \_\_\_\_\_

Was this an accident? yes  no  Is this a W.S.I.B. case? yes  no

Do you consider the disability to be the result of: a) Intentionally self-inflicted sickness or injury? yes  no   
b) Pregnancy? yes  no

Did disability occur during employee's vacation? yes  no

If yes, specify vacation period: \_\_\_\_\_

Last day worked: 

day	month	year

Hourly rate of Pay: \$ \_\_\_\_\_ / hr.

Date returned or expected to return to work: 

day	month	year

Regular days off: Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.  Sun.   
Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.  Sun.

(if irregular indicate days off for sickness period)

Date: \_\_\_\_\_ Position: \_\_\_\_\_ Signature: \_\_\_\_\_

