UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

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

APPLICATION FOR DISABILITY INCOME BENEFITS - CLAIMANT'S STATEMENT

This Form will be returned to you if it is incomplete or contains errors

SIN _____ Name _____
(First) (Last)

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

Phone Number _____ Date of Birth _____ Email _____

Employment Position on date of disability (Please provide a brief description of your Regular Job Duties):

_____

_____

Employee Number: _____ Location: ☐ Winnipeg ☐ Brandon ☐ Paquin ☐ Hamilton ☐ London

On the day you stopped working as a result of your disability, were you employed in any other occupation other than your position at Maple Leaf Foods Inc.? ☐ No ☐ Yes - where? _____

HISTORY

1. What is the nature of your condition? _____
2. Have you had this illness/injury before? ☐ No ☐ Yes

   If "Yes", when, how long did it last and what was the treatment: _____

   _____
3. From what date has the illness/injury continuously prevented you from performing the duties of your regular occupation?

   Year _____ Month_____ Day _____

   What prevents you from performing your Regular Job Duties? _____

   _____
4. If an injury, when did it occur? Year _____ Month_____ Day _____

   Describe where and how it happened (include Police Report number and Auto Insurance claim number, if applicable):

   _____

   _____
5. Is the illness/injury work-related?

   ☐ No ☐ Yes. If "Yes" has a claim been made to Workers' Compensation? ☐ No ☐ Yes

   NOTE: If your claim was denied or terminated by Workers' Compensation please provide a copy of the letter from them.
6. Have you submitted a claim to E.I. within the last 12 months? ☐ No ☐ Yes

   NOTE: If you answered "Yes", but did not receive your full weeks of benefit, you must apply to E.I. first to complete your entitlement, before claiming under this Plan.
7. Have you been able to work for salary or profit since the commencement of your illness/injury?

   ☐ No ☐ Yes. If "Yes", provide details _____
8. On what date did you first see a Physician for this illness/injury? Year _____ Month _____ Day _____

   Name and address of current Physician(s)_____

   _____

OTHER INCOME (Have you applied for or are you receiving any of the following?)					
Source	Yes	No	Date Application Submitted	Date Benefits Commenced	Date Benefits Ceased
Worker's Compensation					
Employment Insurance					
Manitoba Public Insurance					
Canada Pension Plan					
Self Employment					
Social Assistance					
Other (Specify) _____					

EDUCATION, TRAINING AND EXPERIENCE (Please ensure all upgrading/courses are included)
Last Grade Level Achieved:
Post Secondary Education:
Additional Courses:
Other Language Skills:
Computer Skills:

WORK HISTORY (Please include as many jobs as possible)			
	Job Title/Duties	Employer Name	Length of Employment
1			
2			
3			
4			
5			
6			

AUTHORIZATION/CERTIFICATION AND CONSENT

I understand that it is an offense to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete to the best of my knowledge and belief.

I understand that any information obtained by the Plan administrator will not be disclosed to anyone EXCEPT: insurance companies, third party administrators, administrators of government benefits, physicians, vocational evaluators, my employer, and any institution, or person, on a need to know basis, for the purpose of verifying and/or evaluating benefit entitlements or as may be necessary to prevent or to detect the perpetration of a fraud.

I acknowledge that from time to time, I may be examined by one or more licensed medical doctors, selected by the Board of Trustees, who will submit a report(s) to the Plan administrator.

I authorize my employer to complete and submit to the Plan administrator, Form 2 - APPLICATION FOR DISABILITY BENEFITS - EMPLOYER'S STATEMENT.

I authorize any licensed physician, health care practitioner, hospital, clinic, institution, or other medical or medically related facility, insurance company or similar entity, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or person, that has any record or knowledge of me or my health to release to the Plan administrator: any required medical information. For purposes of this authorization, medical information specifically includes confidential information regarding communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.

I authorize the Plan administrator to release any and all of the information related to this claim to the Board of Trustees and the Rehabilitation Committee, in confidence, when required to resolve my entitlement to benefits.

I authorize the use of my Social Insurance Number, to satisfy the government's reporting requirements and as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that my personal information, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with you; determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy my personal information. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review this information to ensure that it is up-to-date and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

This authorization is valid for the duration of my claim.

A photostatic copy of this authorization will be as valid as the original.

_____	_____
Signature of Claimant	Date
_____	_____
Signature (if other than Claimant)	Date

THE TRUSTEES RESERVE THE RIGHT TO DENY OR TERMINATE BENEFITS AND RECOVER ANY PAYMENTS MADE FOR FAILURE TO DISCLOSE ALL RELEVANT INFORMATION