UNITED FISHERMEN AND ALLIED WORKERS' UNION-Unifor

UFAWU-Unifor SICK CREDITS and EXTENDED SICK CREDITS

If you are a member of the UFAWU-Unifor and you cannot work for the duration of your regular season because of sickness, accident or maternity, please let the Union know.

If you miss paying dues to the Union, the computer tends to think that you are no longer in the industry and you become "not in good standing". To qualify for many benefits, including Honourary Membership, you need to keep your membership 'continuous'.

To remain in good standing, you can apply for Sick Credits, which are FREE for the first year. If you are still disabled from working in a second year you can apply for Extended Sick Credits.

For more information, please call:

UFAWU-Unifor 326 – 12th Street New Westminster V3M 4H6 604 519 3630
or
UFAWU-Unifor 869 Fraser Street Prince Rupert V8J 1R1 250 624 6048 or
1 888 624 6625

1ST FLOOR, 326–12TH STREET
NEW WESTMINSTER, BC V3M 4H6
TEL: 604-519-3644 FAX: 604-524-6944

APPLICATION FOR SICK CREDITS

Any member except an honorary member who becomes unemployed because of sickness or accident or maternity may be granted "sick credits' and shall not be required to pay dues for any month so incapacitated "Sick credits' are limited to a maximum of 12 consecutive months.

NAME (PLEASE PRINT) ______________________ **DATE** ______________

ADDRESS ____

______________________________ **PHONE** ______________

SOCIAL INSURANCE # ______________________

DATE OF BIRTH ______________ **DATE OF INITIATION** ______________

DATE LAST WORKED? ______________

EMPLOYER ____

DATE OF DISABILITY ______________________________________

NATURE OF DISABILITY ____________________________________

____

WHEN DO YOU EXPECT TO RETURN TO WORK? ______________________

All information is true and complete. I consent to the disclosure of this personal information to UFAWU-UNIFOR, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

______________________ ______________________

DATE SIGNATURE OF MEMBER

FOR OFFICE USE

COMMENTS ____

____

SICK CREDIT DUES APPROVED FROM ______________ TO ______________

(FISCAL DUES YEAR IS MAY 1 TO APRIL 30)

AMOUNT PAID ______________ **RECEIPT NO** ______________

DATE ______________ **SIGNATURE:** ______________________

PHYSICIAN'S STATEMENT OF DISABILITY

NAME OF PATIENT: ______________________________

HOW LONG HAVE YOU KNOWN THIS PATIENT: ______________________________

____

DIAGNOSIS: ______________________________

____

DATE OF DISABILITY: ______________________________

DATE OF LAST EXAMINATION: ______________________________

PROGRESS: RECOVERED ☐ UNIMPROVED ☐

IMPROVED ☐ RETROGRESSED ☐

WHEN DO YOU THINK THE PATIENT WILL BE FIT TO WORK?

APPROXIMATE DATE: ____________________ 20 _____ INDEFINITE ☐ NEVER ☐

____

____

IS THE PATIENT, TOTALLY AND PERMANENTLY DISABLED AND THEREBY PREVENTED FROM ENGAGING IN ANY GAINFUL EMPLOYMENT? ____________________

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____

DATE: ____________________ **NAME OF PHYSICIAN:** ____________________

ADDRESS: ______________________________ **PHONE:** ____________________

SIGNATURE: ______________________________

UFAWU | UNIFOR
United Fishermen & Allied Workers' Union

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APPLICATION FOR EXTENDED SICK CREDITS

Any member who has been totally disabled by illness or accident for a period in in excess of 12 months may apply for Extended Sick Credits. This privilege shall not be granted if the member's total disability was caused by an accident while employed outside the fishing industry. Extended sick credits shall be limited to three years after the end of the year in which the member last worked.

NAME (PLEASE PRINT) ______________________ **DATE** ____________

ADDRESS ____

______________________________________ **PHONE** ____________

SOCIAL INSURANCE # ______________________________

DATE OF BIRTH __________________ **DATE OF INITIATION** ____________

DATE LAST WORKED? ______________

EMPLOYER ____

DATE OF DISABILITY ______________________________________

NATURE OF DISABILITY ____________________________________

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____

All information is true and complete. I consent to the disclosure of this personal information to UFAWU-UNIFOR, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

______________________ ______________________

DATE SIGNATURE OF MEMBER

FOR OFFICE USE

COMMENTS ____

____

EXTENDED SICK CREDIT APPROVED FROM ______________ TO ______________

(DUES FISCAL YEAR IS MAY 1 TO APRIL 30)

AMOUNT PAID ______________ **RECEIPT NO** ______________________

DATE __________________ **SIGNATURE:** ______________________

INSTRUCTIONS

1. **If you have made an application for Total disability or Weekly Indemnity benefits, this application form will be verified by the Benefit Fund office.**
2. **If you do not have a current claim for benefits from the Benefit Fund office, then proof of disability must be provided. This could be payments of other disability benefits such as WCB wage loss, ICBC wage loss, Canada Disability Pension (Code 5) or EI benefits. If none of these is available, please have your physician complete the statement below.**
3. **UFAWU-UNIFOR is not responsible for any fees for completion of this form.**

PHYSICIAN'S STATEMENT OF DISABILITY

NAME OF PATIENT ______________________________

DIAGNOSIS ______________________________

DATE OF LAST EXAMINATION ______________________________

PROGRESS:

RECOVERED ❑ STABLE ❑

IMPROVED ❑ RETROGRESSED ❑

IS THE PATIENT TOTALLY DISABLED FOR THE NEXT 12 MONTHS FROM ENGAGING IN ANY TYPE OF GAINFUL EMPLOYMENT (IF IT IS UNCERTAIN, PLEASE INDICATE WHEN THE PATIENT WILL BE REASSESSED FOR A RETURN TO WORK) ______________________________

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DATE ______________________________

NAME OF PHYSICIAN ______________________________

PHONE ______________________________

ADDRESS ______________________________

____

SIGNATURE ______________________________