BENEFITS CONTINUANCE FORM

Last Name _____ First Name _____ Email Address _____

Address _____ City _____ Postal Code _____

Home Phone _____ Cell Phone _____

Employer _____ Employee # _____

Start Date (Year/Month/Day) _____ Date Sick Leave Ended (Year/Month/Day) _____

Employment Insurance:

Application Date _____ Date Benefits Started _____ Date Benefits Denied _____

WCB:

Is your absence from work due to a workplace related illness or injury? Yes ☐ No ☐

Have you applied for WCB benefits? Yes ☐ No ☐

Has your claim been denied? Yes ☐ No ☐

Have you submitted an appeal? Yes ☐ No ☐

Please be aware that if the union covers your benefits during a period when you are appealing a WCB claim you are responsible to repay the union should your appeal be successful and your claim is backdated to the date of the original claim.

Long Term Disability:

_____ How long must you be off work before benefits commence? _____
Application Date Days/Weeks

Has your claim been accepted? Yes ☐ No ☐: _____
Date Claim Accepted

Important:

Please attach a copy of the employer letter indicating when your benefits ended and the date and amount you must pay in order to ensure benefit coverage. The application for benefits continuance requires several weeks to process and approve. Please make every effort to forward the completed form and required attachment as soon as possible to minimize a lapse in benefit coverage.

Rmm
CEP Local 467-UW
BenefitContinuance.Form