LiUNA Local 1059 Benefit Trust

W.A. Health Inc. 149 Main St E, Hamilton ON L8N 1G4 • (289) 768-3621 • claims@wahealth.ca

PARENTAL LEAVE CLAIM FORM

A GENERAL INFORMATION

Active members who wish to spend time with their family immediately following the birth of a biological or newly adopted child(ren) may be eligible to receive parental leave benefits. This benefit is provided to members (not dependents) who had loss of earnings up to 3 consecutive business days. Benefits are payable for days that you are absent from work only and not for periods of unemployment. Members making pay-direct contributions at the time of birth or adoption are not entitled to this benefit. Parental leave benefit payments are taxable and you will receive a T4A from W.A. Health.

To be eligible for this benefit you must:

- **Be absent from work immediately following the birth of your child or the date on which your child was placed with you by an adoption agency**
- **Submit a temporary Health Card from the hospital or a birth certificate or adoption papers along with this claim form**
- **Submit an updated Group Benefits Enrolment and Beneficiary Designation Form which is available from the Union Office or W.A. Health**

B TO BE COMPLETED BY PLAN MEMBER

Full Name _____ Social Insurance No. or Certificate No.: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Name of Biological/Adopted Child (1): _____

Date of Birth of Biological Child: _____|_____|_____ (Day | Month | Year) Date of Adoption: _____|_____|_____ (Day | Month | Year)

Name of Biological/Adopted Child (2): _____

Date of Birth of Biological Child: _____|_____|_____ (Day | Month | Year) Date of Adoption: _____|_____|_____ (Day | Month | Year)

Number of Work Days Lost: _____

Signature of Plan Member: _____ Date: _____|_____|_____ (Day | Month | Year)

C TO BE COMPLETED BY EMPLOYER

Employee Name: _____ Company Name: _____

Name of Authorized Representative: _____ Title of Authorized Representative: _____

Last Date at Work Before Interruption: _____|_____|_____ (Day | Month | Year) First Date at Work After Interruption: _____|_____|_____ (Day | Month | Year)

Number of Work Days Lost by the Employee: _____

I hereby declare the above named employee had loss of earnings by interruption of the employment otherwise available and normally performed by him or her, to the extent indicated above.

_____ Phone Number of Authorized Representative

_____ Signature of Authorized Representative

_____|_____|_____ Date (yyyy-mm-dd)

Benefits Administered by

H E A L T H

Email this form and supporting documents to:
claims@wahealth.ca