UNITED FOOD AND COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN – ONTARIO

Please mail this form to:

PBAS
110-61 International Blvd.
Toronto, ON M9W 6K4

Absence From Work Form

Part I – Employee

First Name: _____ Last Name: _____

Member ID/SIN: _____ Phone #: _____

Address: _____

_____

City: _____ Postal: _____

Part II – Employer

Company: _____

This employee has been absent from work due to: *(please check one)*

- ○ (a) Occupational Injury or Illness
- ○ (b) Non Occupational Injury or Illness
- ○ (c) Lay Off
- ○ (d) Maternity/Parental Leave
- ○ (e) Other _____
- ○ (f) Approved Leave of absence _____ (other than option (d))

Date absence Commenced: _____ Date Expected Return to Work: _____

EMPLOYER

Full Name: _____ Title: _____

Phone #: _____ Date: _____

Email: _____

_____

Authorized Signature: _____

Part III – Employee

Self payments can be made to continue dental coverage IF absence is due to Lay Off, Leave of absence, or Early Retirement.
Please check with the Plan Administrator prior to submitting any payment.

I wish to make self payment(s) for the month(s) of _____.

I have enclosed a cheque, or money order in the amount of $ _____, payable to the **United Food and Commercial Workers Trusteed Dental Fund – Ontario**.

☐ I hereby certify that I have not engaged in any occupation or employment, other than with an employer participating in the plan, since my absence commenced.

Signature: _____ Date: _____