CLAIM FORM

Facilities Bargaining Association and the HEABC
Bill 29-2002 Settlement Agreement – Joint Governance Committee
(Please print clearly)

1. Claimant name: _____

2. Current or forwarding address: _____

3. Previous address at date of displacement: _____
   Note: Only complete if this address is different from current or forwarding address.

4. Phone number: (___) _____ E-mail: _____

5. Social Insurance Number: _____ Union affiliation: _____

6. Job classification/title at date of displacement: _____

7. Health Sector Employer which displaced you: _____

8. Current Employer: _____

9. For **regular** employees only: Did you receive a displacement notice eliminating your regular position due to contracting out, due to a closure of a Health Sector facility, or due to a bump by a more senior employee?

   Yes: ☐ No: ☐

10. For **casual** employees only: Did you receive a notice terminating your employment due to contracting out or due to a closure of a Health Sector facility?

    Yes: ☐ No: ☐

COMPLETE ONLY ONE OF SECTION A OR B OR C, as applicable to your circumstances.

IF YOU COMPLETE SECTION A OR B, YOU MUST ALSO COMPLETE ALL OF SECTIONS D, E, F, and G.

IF YOU COMPLETE SECTION C, DO NOT COMPLETE SECTIONS D, E, and F. PROCEED TO SECTION G.

SECTION A

LOSS OF JOB/EMPLOYMENT *(due to contracting out or restriction of bumping rights)*:

What was your length of service as a **regular** employee at the date of displacement which resulted in the loss of your job/employment? *Note: Length of service does not include any time spent as a casual employee.*	Over 20 years:	☐
	16 to 20 years:	☐
	11 to 15 years:	☐
	6 to 10 years:	☐
	0 to 5 years:	☐

What was the length of time you were without employment following the loss of your job/employment?	Over 1 year: 6 months to 1 year: Up to 6 months:	☐ ☐ ☐
What was your employment status at the time of the loss of your job/employment in the Health Sector?	Regular full-time: Regular part-time: Casual:	☐ ☐ ☐
If you were a **casual** employee at the termination of employment, what was the length of your employment?	Over 5 years: 0 to 5 years:	☐ ☐
What is the difference between your gross (before deductions) annual income in the Health Sector prior to the loss of your job/employment compared to your subsequent gross annual income? *Note: Annual income includes pension income and income from any Employer regardless of where you were re-employed.*	Over $20,000 less per year: $10,001 to $20,000 less per year: $5,001 to $10,000 less per year: $0 to $5,000 less per year:	☐ ☐ ☐ ☐

If you completed Section A above, proceed to Section D and complete through to Section G.

SECTION B

LOSS OF JOB/EMPLOYMENT *(due to facility closure and reduced layoff notice period)*:

What was your length of service as a **regular** employee at the date of closure? *Note: Length of service does not include any time spent as a casual employee.*	Over 5 years: Over 3 years to 5 years: 0 to 3 years:	☐ ☐ ☐
What was your employment status at the time of the loss of your job/employment in the Health Sector?	Regular full-time: Regular part-time: Casual:	☐ ☐ ☐
If you were a **casual** employee at the termination of employment, what was the length of your employment?	Over 5 years: 0 to 5 years:	☐ ☐

If you completed Section B above, proceed to Section D and complete through to Section G.

SECTION C

LOSS OF EARNINGS DUE TO A BUMP:

Are you in a lower paying position in the Health Sector as a result of exercising a bumping option?	Yes – more than $3.00 per hour less: Yes – between $1.01 and $3.00 per hour less: Yes – up to $1.00 per hour less: No:	☐ ☐ ☐ ☐
Are you working fewer hours per week in the Health Sector as a result of exercising a bumping option?	Yes – more than 15 hours per week less: Yes – between 7.5 and 15 hours per week less: Yes – up to 7.5 hours per week less: No:	☐ ☐ ☐ ☐

If you completed Section C above, proceed to Section G.

SECTION D

LOSS OF HEALTH AND WELFARE BENEFITS:

Do you have 100% Employer-paid health and welfare benefits in your current employment?	Yes: No:	☐ ☐
Do you have a Dental Plan in your current employment?	Yes: No:	☐ ☐
Do you have access to a Long-Term Disability Insurance Plan in your current employment?	Yes: No:	☐ ☐

SECTION E

LOSS OF PENSION BENEFITS:

Do you have access to a pension in your current employment? *Note: If you are in receipt of a pension, do not answer this question.*	Yes: No:	☐ ☐
Is your pension plan a Group RSP or a Public Sector Pension Plan (e.g., Municipal Pension Plan or Public Service Pension Plan)?	Group RSP: Public Sector Pension Plan:	☐ ☐
Did you take early retirement as a result of being issued a displacement notice and start collecting a Public Sector Pension Plan?	Yes: No:	☐ ☐

SECTION F

ENHANCED SEVERANCE:

Did you collect an Enhanced Severance as a result of layoff due to contracting out?	Yes – received a gross payment of between $11,001 and $17,000:	☐
	Yes – received a gross payment of up to $11,000:	☐
	No:	☐

SECTION G

I hereby certify the information I have provided in this Claim Form is true to the best of my knowledge. I acknowledge that a failure to complete this Claim Form honestly and in its entirety may result in the forfeiture, in whole or in part, of any claim to a payment. I also acknowledge that by completing this Claim Form, I authorize the production of any relevant supporting documents (e.g., T4 and T4A information slips, pay stubs) if requested by HEABC and/or by the Facilities Bargaining Association. I acknowledge that if I am eligible to receive a payment from the fund as a result of a loss of my employment, I am relinquishing any right to reinstatement to my previous position in the Health Sector.

Signature of Claimant: _____

Date Claim Form Completed: _____, 2008.

Privacy Statement:

The information in this Claim Form is confidential and will be used only for the purposes of determining eligibility for and the payment of an amount to eligible claimants pursuant to the HEABC/FBA Bill 29-2002 Settlement Agreement. By completing and signing this Claim Form, the claimant agrees to have his/her personal information collected and used for this specific purpose.

***** This Claim Form must be submitted to your Union on or before June 15, 2008. *****