UFCW 247
BENEFIT TRUST FUND

MISSING HOURS FORM

Please Print:

First Name _____ Last Name _____ Certificate Number or SIN Number _____

Complete Mailing Address _____ Telephone Number _____

City _____ Postal Code _____ Email _____

TO BE COMPLETED BY THE EMPLOYER

This is to certify that the above named employee has been/will be absent from work for the following reason(s):

	Exact Date Leave Commenced	**Expected Date of Return**
☐ medical injury/illness	_____	_____
☐ on approved leave of absence	_____	_____
☐ maternity/parental leave	_____	_____
☐ restricted hours	_____	_____
☐ other (please specify)	_____	_____

TO BE COMPLETE BY THE EMPLOYER

Date _____ **Title** _____ **Print Name** _____

Name of Employer _____ **Telephone** _____ **(Ext#)** **Authorized Signature** _____

Email _____

To be completed by the Member:

I hereby certify that the information provided above is correct to the best of my knowledge.

Date _____ **Member Signature** _____

** Please return the ***completed*** form via email: **247benefits@pbas.ca** - or to the address below**

103-14936 32 Avenue, Surrey, BC V4P 3R5
Tel: 604-945-7607 Toll Free: 1-800-663-7977 Fax: 604-945-7657