



# IBEW LOCAL 353

## Pension & Benefits Plan

### Family Medical Leave Form

Complete, sign and date this form in order to maintain your benefit coverage and pension credits during Family Medical Leave and return to TEIBAS for processing. If you have any questions or need any assistance in completing this form please contact TEIBAS at 416-637-6789 or 1-800-267-0602 (toll free).

A member can take Family Medical Leave of up to 28 weeks in a 52-week period to provide care or support to certain family members if a qualified medical practitioner has issued a certificate stating that the family member has a serious medical condition with a significant risk of death occurring within a period of 28 weeks. The member may take the leave in one-week periods within a specified 26-week period. All leaves are subject to the provisions and standards outlined in the *Ontario Employment Standards Act*.

#### 1. Member Information (please print clearly in ink) – Required

Social Insurance Number (SIN) - (optional)	PIN – 10-digit number found on drug card	
Last Name	First Name	Middle Initial(s)

#### 2. Leave Information

Employer Name	
Leave Start Date (DD/MM/YYYY)	Leave End Date (DD/MM/YYYY)

#### 3. Requirements

When submitting this form, you must include:

Documentation from a qualified health practitioner (as soon as it is available) indicating that the specified family member has a serious medical condition with a significant risk of death within a period of 26 weeks. There is no requirement that the documentation specify the nature of the illness or the diagnosis.

As you may qualify for Supplemental Unemployment Benefits (SUB), contact the IBEW Local 353 Union Hall at 416-510-3530.

You must be covered under the IBEW Local 353 Group Benefit Plan prior to receiving family medical leave benefit coverage and pension credits. Your health and welfare benefit coverage and pension credits will be based on the leave dates indicated on your application form. For leaves starting or ending mid-month, credits will be pro-rated.

#### 4. Specified Family Members

Select one of the following specified individuals for whom a family medical leave may be taken for:

<input type="checkbox"/> the employee's spouse (including same-sex spouse) <input type="checkbox"/> a parent, step-parent or foster parent of the employee or of the employee's spouse <input type="checkbox"/> a child, step-child or foster child of the employee or of the employee's spouse <input type="checkbox"/> a brother, step-brother, sister or step-sister of the employee	<input type="checkbox"/> a brother-in-law, step-brother-in-law, sister-in-law or step-sister-in-law of the employee a grandparent or step-grandparent of the employee or of the employee's spouse a grandchild or step-grandchild of the employee or of the employee's spouse a son-in-law or daughter-in-law of the employee or of the employee's spouse	an uncle or aunt of the employee or of the employee's spouse a nephew or niece of the employee or of the employee's spouse the spouse of the employee's grandchild, uncle, aunt, nephew or niece Family medical leave could also be taken for a person who considers the member to be like a family member*
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\*If selecting this category, you must provide a completed [Compassionate Care Benefits Attestation Form](#), available from [www.canada.ca](#)

I consent to the collection, use and disclosure of all information provided on this form for the purposes outlined in the TEIBAS Privacy Policy. I also certify that all of the information provided on this form is correct and accurate to the best of my knowledge.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (DD/MM/YYYY)



Mail, fax, or scan and email to [members@teibas.com](mailto:members@teibas.com)

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