

## A Member Information *(Please Print)*

Last Name	First Name	Gender	Male	Female
Address		Date of Birth (yyyy/mm/dd)		
Town/ City	Prov.	Postal Code	Country	
Member Advantage Benefit Card ID Number (last 10 digits)		Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID		
Email Address		Phone #		
Marital Status	Married Common-Law	Single Separated	Divorced Widow	Cell #

## B Claim Information

**In order to properly and accurately address your claim, please provide photocopies of all pay stubs, showing vacation pay deductions, for all work months.**

Vacation Pay Fund:                      HVP                      SHP

Work Months: \_\_\_\_\_

Company Name: \_\_\_\_\_

Company No.: \_\_\_\_\_

Type of Problem: \_\_\_\_\_

Cheque No.: \_\_\_\_\_

## C Member Authorization

Member Name: \_\_\_\_\_ (Print Name)                      Date: \_\_\_\_\_

Member Signature: \_\_\_\_\_                      Witness: \_\_\_\_\_