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Supplementary Hours Credit ("SHC") Application

Complete this application to continue to earn pension credits while off work due to illness or injury, or for maternity, parental, or adoption leaves, and return it to us along with the additional information detailed below. You must be under age 65 and have previously completed a *Registration of Personal Information and Beneficiary Designation* form.

Tip! Once completed, take a photo of this form to keep a copy for your records.

1. Member Information

Last Name | First Name | Member ID

Email | Phone (Primary) | Date of Birth (YYYY/MM/DD)

Apt./Unit | Street No. | Street Name | City/Town | Province | Postal Code

Employer | Date of Hire (YYYY/MM/DD)

Employment Status

This credit is based on the hours reported by your employer in the calendar year prior to your leave, so it is important that you let us know if you were absent from work for any reason, or if there was a change in your employment status (full-time to part-time or vice versa), during the prior calendar year. Did your employment status change in the calendar year prior to your leave? If yes, provide details below. If no, proceed to the next section.

Absence from (YYYY/MM/DD) - to - (YYYY/MM/DD) | Date of Change to Part-Time (YYYY/MM/DD) | Date of Change to Full-Time (YYYY/MM/DD)

2. Details of Leave

Provide the start and end dates below for only the type of leave applicable to you. A Physician's Statement (see next page) must be completed by your physician for disability and preventive leaves. You are responsible for any fees charged by your physician. If you have not yet returned to work, indicate **none** in the applicable Return to Work field below.

Disability (illness or injury)

You must apply within 6 months from the start of your leave. **Physician's Statement required.**

Start Date (YYYY/MM/DD)

Return to Work Date – **Modified Hours** (YYYY/MM/DD)

Return to Work Date – **Regular Hours** (YYYY/MM/DD)

Preventive (disability resulting from pregnancy)

You must apply within 60 days following your return to work. **Physician's Statement required.**

Start Date (YYYY/MM/DD)

Return to Work Date (YYYY/MM/DD)

Maternity/Parental/Adoption

You must apply within 60 days following your return to work. **Proof of birth/adoption required.**

Start Date (YYYY/MM/DD)

Delivery/Adoption Date (YYYY/MM/DD)

Return to Work Date (YYYY/MM/DD)

3. Declaration

I certify that the information I have provided on this form is true and accurate. I understand that personal information on this form is being collected, stored, used, and disclosed to third parties under contract with the Plan to provide pension services. I understand that all personal information will be kept confidential, will only be used to determine my benefit entitlement, and while I may withhold or revoke my consent for its use, doing so may limit the Plan's ability to determine my benefit entitlement and my participation in the Plan may be impaired. By providing my email address, I consent to the receipt of electronic communications.

Member's Signature | **Date** (YYYY/MM/DD)

4. Verification (Internal CCWIPP use only – do not complete this section)

Employer | Verifier's Name | Verifier's Title

Phone (Primary) | Verifier's Signature | Date (YYYY/MM/DD)

See next page for Physician's Statement.

5. Physician's Statement

Member Authorization

I authorize the release of the information requested below to CCWIPP on the understanding that all personal information will be kept confidential and will only be used to determine my benefit entitlement.

Member's Signature | Member ID | Date (YYYY/MM/DD)

The rest of this form must be filled out by your physician.

Please complete all fields below. We will treat, as being wholly confidential, all information disclosed herein and will take all steps necessary to protect the confidentiality thereof from further disclosure, exploitation, or abuse. We reserve the right to request additional information including but not limited to a second medical opinion.

Patient Information

Patient Last Name | Patient First Name | Date Patient Became Unable to Perform the Duties of Their **Regular** Occupation (YYYY/MM/DD)

Nature of Disability (Diagnosis)

Frequency of Visits (Weekly/Monthly/Other) | Date of Last Visit (YYYY/MM/DD) | Is Disability Permanent (Yes/No) | If **No**, Return to Work Date or Expected Return to Work Date (YYYY/MM/DD)

Physician Information

Physician Last Name | Physician First Name | Licence/Registration

Email | Phone (Primary)

Suite/Unit | Street No. | Street Name | City/Town | Province | Postal Code

Physician's Signature | Date (YYYY/MM/DD)