rrecc/ccwipp

Régime de retraite des employés de commerce du Canada

Canadian Commercial Workers Industry Pension Plan

# Application For Continuing Pension Accruals

## Supplementary Hours Credit ("SHC")

If you are under age 65, have completed a Registration of Personal Information and Beneficiary Designation Form and are unable to work due to illness or injury; or you were away from work because of a maternity, parental or adoption leave, you may apply for SHC to have pension accruals continue.

The calculation of this credit is based on the hours reported by your employer, in the calendar year prior to your period of disability or leave. Therefore, when applying for SHC 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) in the prior calendar year.

## INSTRUCTIONS – SEE REVERSE FOR APPLICATION FORM

### ➢ TO APPLY FOR SHC DUE TO ILLNESS OR INJURY…

If your disability lasts less than 30 days, you must apply within **60** days following the date you return to work.

If your disability lasts 30 days or more, you must apply within **6** months from the beginning of your illness or injury.

Complete **Part 1** "Member Information", **Part 2** "Disability" and **Part 4** "Member Certification". Then, on the "Physician's Statement" complete the "Member Authorization" section and take this form to your doctor for completion. You are responsible for any fees charged by your physician.

### ➢ TO APPLY FOR SHC DUE TO PREVENTIVE (disability leave as a result of pregnancy), MATERNITY, ADOPTION OR PARENTAL LEAVE…

If you are off on preventive, maternity, parental or adoption leave, you must apply within **60** days following the date you return to work.

Complete **Part 1** "Member Information", **Part 3** "Preventive (if applicable), Maternity, Adoption or Parental Leaves" and **Part 4** "Member Certification". It is **not** necessary to complete Part 2 or the "Physician's Statement" unless you were prevented from working, as a result of pregnancy, prior to commencement of maternity leave. You are required to **provide proof of birth or evidence of adoption** of your child or children.

If you have any questions regarding SHC, please call the Administrator at **1-800-563-1930**.

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Return the completed forms to the Administration office in your region.


**110-61 International Boulevard**
**Toronto, ON M9W 6K4**
**contact@ccwipp.ca**
**1-888-7CCWIPP**
**ccwipp.ca**

**201-1200, boul. Crémazie Est**
**Montréal, QC H2P 3A5**
**contactez@rrecc.ca**
**1-888-97RRECC**
**rrecc.ca**

**3RD-880 Portage Avenue**
**Winnipeg, MB R3G 0P1**
**contact@ccwipp.ca**
**1-888-7CCWIPP**
**ccwipp.ca**

# Application For Supplementary Hours Credit – Member Statement

## PART 1: MEMBER INFORMATION

Plan Membership No:_____

Name:_____ Date of Birth:_____/_____/_____
Year Month Day

Street Address:_____

Town/City:_____ Province:_____ Postal Code:_____

Telephone No.: _____ Email Address: _____

Employer:_____ Date of Hire:_____/_____/_____
Year Month Day

Did your Employment Status change in the calendar year prior to your Disability or Leave? ☐ No ☐ Yes

If Yes, from Full-time to Part-time on:_____/_____/_____ **OR** Part-time to Full-time on:_____/_____/_____
Year Month Day Year Month Day

## PART 2: DISABILITY

I became unable to work on _____/_____/_____ due to an illness/injury which prevented me from
Year Month Day
performing the duties of my regular occupation or any other gainful employment.

☐ I have not returned to work, or

☐ I returned to **modified hours** of work on:_____/_____/_____, **or**
Year Month Day

☐ I returned to **regular hours** of work on:_____/_____/_____
Year Month Day

## PART 3: PREVENTIVE LEAVE

**Physician's Statement must be completed**

☐ Preventive

Preventive Start Date:_____/_____/_____
Year Month Day

Preventive End Date: _____/_____/_____
Year Month Day

## MATERNITY/ADOPTION/PARENTAL LEAVES

**Provide proof of birth/adoption**

Type of leave: ☐ Maternity ☐ Adoption ☐ Parental

Date Leave Commenced:_____/_____/_____
Year Month Day

Date of Delivery/Adoption:_____/_____/_____
Year Month Day

☐ I returned to work on:_____/_____/_____
Year Month Day

☐ I have not returned to work

## PART 4: MEMBER CERTIFICATION

I certify that, to the best of my knowledge and belief, the information given in this form is true, correct and complete.

I hereby authorize the Trustees and the administrator of CCWIPP to collect, record, retain, disclose, and if applicable, destroy the personal information, referenced herein. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purpose of determining and calculating my benefit entitlement. Also, I understand that I may review my personal information, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine my benefit entitlement, my participation in CCWIPP may be impaired.

Signature of Plan Member:_____ Date:_____

## PART 5: VERIFICATION (for Administrator's Use)

Employer:_____ Name of Verifier:_____

Telephone Number:_____ Title:_____

Signature:_____ Date:_____

**NOTE: THE BOARD OF TRUSTEES RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION AND/OR A SECOND MEDICAL OPINION.**

# Application For Supplementary Hours Credit

## Physician's Statement

### MEMBER AUTHORIZATION

Plan Membership No.:_____

I authorize the release of the information requested herein to the administrator of the Canadian Commercial Workers Industry Pension Plan, on the understanding that this information will be used solely for the purpose of determining my entitlement to Supplementary Hours Credit, and on the further understanding that this information will be kept confidential and secure and will be destroyed when it is no longer required or when my consent has been revised or revoked.

Signature of Plan Member:_____ Date:_____

### PATIENT'S INFORMATION

Patient's Name:_____

Date patient first became unable to perform the duties of his/her REGULAR occupation:_____/_____/_____
Year Month Day

Nature of Disability (Diagnosis):_____

_____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other:_____

Date of Last Visit or Treatment:_____

Is Disability considered permanent? ☐ Yes ☐ No

If **No**, please indicate date patient returned or will return to work:_____/_____/_____
Year Month Day

Name of Physician (please print):_____License/Registration No.:_____

Address:_____

_____Telephone No.:_____

Signature of Physician:_____ Date:_____

As the administrator of the **Canadian Commercial Workers Industry Pension Plan**, we covenant and agree to treat, as being wholly confidential, all the information disclosed, herein, and further agree to take all of the steps needed to protect the privacy of the said information from further disclosure, exploitation or abuse.

**NOTE: THE BOARD OF TRUSTEES RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION AND/OR A SECOND MEDICAL OPINION.**