HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

FIN 15.03(a)

Wage Reimbursement Claim Form

(complete only if your employer is ***not*** billing HSA directly)

Member ID# _____ SIN# _____

Name _____ Work phone _____ Ext. _____
(Surname) (First Name)

Home address _____
(Street Address) (City) (Postal Code)

Facility _____ Discipline _____

Event date(s) from _____ to _____ Status ○ Casual

Event _____ ○ Part-time

Held at _____ ○ Full-time

Wage reimbursement (SIN# required for T4 purposes)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date(s)							
Straight Time Hours							
Hourly Rate							
Subtotal Wages							

DECLARATION:

I declare that I have completed this form accurately and, in making this application to be paid out banked union leave, I acknowledge that, in all instances when I earn compensation from HSA related to banked union leave (i.e. employment income) AND I am also in receipt of benefits payable pursuant to an insurance (e.g. long term disability) or statutory (e.g. employment insurance) scheme, I will comply with all reporting requirements of the insurance or statutory scheme.

Signature: _____ Date: _____

Please send your completed form to the Accounts Payable department at HSABC:

By Mail: 180 East Columbia Street, New Westminster, BC V3L 0G7

By email: Payable@hsabc.org **By facsimile:** 604-515-8889, toll free 1-800-663-6119

Do not write in shaded area (for office use only)

Benefit Amount							
GROSS WAGES							

HSA is committed to using the personal information we collect in accordance with applicable privacy legislation. By completing this form, you are consenting to have HSA use the submitted information for the purposes of conducting our representational duties as a union, and in providing service to our members. For further information, please contact the HSA Privacy Officer. The full HSA policy is available online at www.hsabc.org.