

FIN 15.03(a) Wage Reimbursement Claim Form

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

Member ID#	SIN#										
Name(Surname) (First Name)				Work phone		Ext					
Home address(Street Ad	ddress(Street Address) (City					(Postal Co	de)				
Facility			Disci	oline	ine						
Event date(s) from	to Status 🛛 Casual										
Event	ent 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.