



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 Address) _____ (City) _____ (Postal Code) _____

Facility _____ Discipline _____

Event date(s) from _____ to _____ Status Casual
 Part-time
 Full-time

Event _____
Held at _____

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							