LiUNA! Pension Fund
OF CENTRAL AND EASTERN CANADA

WORKERS' COMPENSATION BOARD AUTHORIZATION FORM

MEMBER INFORMATION

Social Insurance Number	Date of Birth (yyyy/mm/dd)	Home Local	Gender
Last Name	First Name	Middle Name	
Address			Apt/Suite #
City	Province	Postal Code	Country
Email	Primary Phone	Other Phone	

Claim Number(s)	Date of Injury (yyyy/mm/dd)	Name of Employer

AUTHORIZATION AND SIGNATURE

I,_____hereby authorize the LiUNA
(print name)

Pension Fund of Central & Eastern Canada (LPF) to request any information from the Workers' Compensation Board concerning my absence(s) from work as identified above as a result of a work-related injury or disability and authorize the Workers' Compensation Board to provide LPF with this information.

Signature	Date (yyyy/mm/dd)