Trillium Gift of Life Network
157 Adelaide Street West, Box 606
Toronto, Ontario M5H 4E7
Ph: 416-619-2342 or 1-888-977-3563 *(1-888-9PRELOD)*
Email: PRELOD@giftoflife.on.ca

Program for Reimbursing Expenses of Living Organ Donors – PRELOD

Income and Benefit Verification Form

● SECTION B1: Consent & Authorization – To be completed by the Claimant

I, *(please print)*_____, the undersigned, understand that in making an application to Trillium Gift of Life Network's PRELOD program, I am required to provide certain information to the Network. My signature below authorizes my employer to release the required information to the Network. I acknowledge that the information that I have provided on this form is accurate and complete to the best of my knowledge, and that I may be required to provide additional information (e.g. Social Insurance Number) for identification verification purposes upon request.

I understand that the personal information provided in this application will be used only for the purposes of establishing my eligibility for expense reimbursement from Trillium Gift of Life Network (TGLN) and for compilation of demographic and statistical information. I further understand that no personally identifiable information will be disclosed in the reporting of any demographic or statistical information. If you have concerns about how TGLN manages your personal information please see www.giftoflife.on.ca or call the Privacy Officer at 416-363-4001 or 1-800-263-2833.

B1:a Date of Birth: _____ *B1:b* Postal Code: _____

B1:c City: _____

_____ _____

✓ Signature ✓ Date

● SECTION B2: Self-Employed Claimants

If Income Tax, Canada Pension Plan, Employment Insurance (E.I) Contributions and other payroll deductions are not taken from your employment income, do not complete Section B4. Please contact the PRELOD Administrator.

● SECTION B3: Employer Information – To be completed by the Employer

B3:a Employer Name: _____ *B3:b* Tel: _____

B3:c Employer Address: _____ *B3:d* Fax: _____

B3:e City: _____ *B3:f* Postal Code: _____

B3:g This form was completed by: _____

B3:h Position: _____ *B3:i* Email: _____

● SECTION B4: Loss of Income Claim Form

See over for the *Loss of Income Claim Form*. Employers are asked to complete Section B4 to support their Employee's claim to PRELOD's loss of income subsidy. *Section B4 does not need to be completed by Self-Employed Claimants.*

Once Section B1, B3 and B4 are completed by Claimant and Employer, please return the form in a confidential envelope to:

PRELOD Program Administrator
Trillium Gift of Life Network
157 Adelaide Street West, Box 606
Toronto, ON M5H 4E7
416-619-2342 or 1-888-977-3563 *(1-888-9PRELOD)*

● SECTION B4: Income Loss Claim Form – For Employer/Claimant

Employee Name: _____

			POST-SURGERY PERIOD							
EMPLOYER	**A**	Information: Last Day of Work: _____ Date of Surgery: _____ Date of Return to Work: _____ ROE Issued: ☐ Y ☐ N	**1** Week of: _____	2 Week of: _____	3 Week of: _____	4 Week of: _____	5 Week of: _____	6 Week of: _____	7 Week of: _____	8 Week of: _____
	B	Weekly **Net** Earnings → ☐ Full-time ☐ Part-time	$	$	$	$	$	$	$	$
	C	55% of Net Income (B X 0.55) →	$	$	$	$	$	$	$	$
	D	Maximum subsidy equals $400 or C, whichever is less. Enter the lesser of Box C or $400 →	$	$	$	$	$	$	$	$
	E	Enter the following other sources of paid income during post-surgery period:								
	E1	Vacation Pay	$	$	$	$	$	$	$	$
	E2	Sick Leave Pay	$	$	$	$	$	$	$	$
	E3	Paid Leave of Absence / Sabbatical	$	$	$	$	$	$	$	$
	E4	Disability Benefits	$	$	$	$	$	$	$	$
	E5	Lieu Time	$	$	$	$	$	$	$	$
	E6	Other Please specify: _____	$	$	$	$	$	$	$	$
	F	Subtotal of E (E1 + E2 + E3 + E4 + E5 + E6) →	$	$	$	$	$	$	$	$
	G	Maximum Claim (D – F) → Enter 0 if maximum claim is negative	$	$	$	$	$	$	$	$
	H	Was the claimant entitled to any other income replacement benefits/paid time off (e.g. vacation time) which they chose not to take? If yes, please provide details, including the amount they could have received.	Details: _____ _____ _____							
	I	**CERTIFICATION:** ***The information provided above is accurate and includes all potential sources of replacement income benefits and paid time off available through the employer while the claimant is recovering from living organ donor surgery.*** **Name of Employer Contact:** _____ **Signature:** _____ **Date:** _____								
CLAIMANT	**J**	Employment Insurance (EI) benefits received (enclose each EI statement received):	$	$	$	$	$	$	$	$
	K	Net Calculation (G –J) → Enter 0 if maximum claim is negative								
		Claimant Signature: _____ **Date:** _____								
		In order to qualify for the loss of income after surgery subsidy, you must include proof of each of the amounts specified in section E or J (e.g. pay or benefits stubs, and /or Employment Insurance benefit statements). Subsidy amounts, if any, will be determined in accordance to the terms and conditions of the PRELOD policy								