TRANSPLANT QUÉBEC

Claim for Income Loss
Reimbursement Program for Living Donors (RPLD)

This form can be completed only after donor's procurement surgery.

Employer guidellines :

Line A : Enter the starting date of the week where the employee has experienced loss of income, or other sources of income, such as vacation pay, sick leave, disability have been or will be provided to the employee.

Line B : Enter the average net earnings that the employee would have received if he/she had worked. Please complete with net income for every week of absence from work, from week 1 to week 8, when applicable.

If weekly net earnings vary, as in the case of hourly paid or commission based employees, please use the average net earnings based on the employee's last six month's income.

Net earnings = Gross income minus (federal taxes, provincial taxes, Québec Pension Plan, Employment Insurance and Québec Parental Insurance Plan)

Line C : For each week of absence, calculate 55% of income calculated on line B.

Line E : For each week of absence, enter the lesser of amounts from lines C and D.

Line F : An employer may have paid other types of income to the employee. For each week of absence, enter the net amount paid in the appropriate line for the type of pay.

Calculate and enter the total of net pay from other sources of income (F1 toF5) on line F6.

Line G : Subtract the total on line F6 from the amount on line E. If the result is negative, please enter zero (0).

Line H : The employee may be eligible to paid vacation or other paid leaves but elected not to receive them. Please fill in the amount he/she could have received.

Employee guidelines:

Line J : Enter the employment benefits (E.I.) you received for each week of your absence from work. Copies of your E.I. benefit statements must be provided for each week you received benefits. If you no longer have your statements, please request a benefits summary from Service Canada (Employment Insurance). If you send your *Claim for Income loss* before receiving information about your E.I. benefits, your application will be kept on hold until such information is provided to RPLD.

Line K : For each week of your absence from work, subtract the E.I. benefits received from the amount in line G. If the result is negative, enter zero (0).

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Claim for Income Loss

Reimbursement Program for Living Donors (RPLD)

This form must be completed by the applicant and the employer.

Applicant information :

Family name of applicant : _____

Given name of applicant : _____

Date of birth of applicant : _____ - _____ - _____
yyyy *mm* *dd*

Last day of work _____ - _____ - _____
yyyy *mm* *dd*

Employer information :

Name of employer : _____

Name of employer's representative : _____

Address of employer : _____
(Number, Street, Appartment)

_____
(City, Province, State, Country, Postal code)

Telephone number of employer : _____

Email of employer: _____

TRANSPLANT QUÉBEC

Claim for lost income

Reimbursement program for living donors (RPLD)

To be completed by the employer	Line	Description	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
	A	Week beginning on (yyyy-mm-dd)								
	B	Net weekly earnings	$	$	$	$	$	$	$	$
	C	55 % of net earnings (B x ,55)	$	$	$	$	$	$	$	$
	D	Maximum weekly compensation	400 $	400 $	400 $	400 $	400 $	400 $	400 $	400 $
	E	Enter the lesser amount between C and D	$	$	$	$	$	$	$	$
	F	Enter amounts received from other sources :								
	F1	Paid vacation	$	$	$	$	$	$	$	$
	F2	Paid sick leave	$	$	$	$	$	$	$	$
	F3	Authorized paid leave/paid sabbatical	$	$	$	$	$	$	$	$
	F4	Disability benefits	$	$	$	$	$	$	$	$
	F5	Other:_____	$	$	$	$	$	$	$	$
	F6	Sub-total (lines F1 to F5)	$	$	$	$	$	$	$	$
	G	Total claim (line E minus line F6)	$	$	$	$	$	$	$	$
	H	Is the applicant eligible for income benefits that he/she declined to receive? (e.g. vacation pay) If so, please indicate the amounts he/she is eligible to receive.	$	$	$	$	$	$	$	$

I hereby declare that the information on this form is accurate and complete and includes all sources of income available to the applicant during his/her post-procurement recovery period.

_____ _____ ____ - ____ - ____

(Name of employer's representative) *(Signature of the employer's representative)* *yyyy* *mm* *dd*

To be completed by the applicat	Line	Description	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
	J	Employment insureance received (include copies of benefit statements)	$	$	$	$	$	$	$	$
	K	Payable claim (line G minus line J)	$	$	$	$	$	$	$	$

I hereby declare that the information provided on this form is accurate and complete and includes all sources of income available to me during my post-procurement recovery period.

I hereby authorize my employer to disclose this information for purposes of administering the RPLD.

_____ _____ ____ - ____ - ____

(Name of applicant) *(Signature of applicant)* *yyyy* *mm* *dd*