



MEMBERSHIP EXPENSE CLAIM FORM (Complete **only** if claiming *wage replacement*)

Ontario Public Service Employees
Union, 100 Lesmill Road,
North York, Ontario M3B 3P8

MEMBER DATA (Please Print) BPS CAAT OPS OTHER EBM

Name: _____ S.I.N./ ID _____ Local: _____

Address: _____

Postal Code: _____ Email: _____

Telephone: (Home) _____ Telephone: (Work) _____

MEETING DATA (Please Print)

NEG. COMM. DIV. CAMP. GRIEV. EDUC.

Name of meeting _____

Location _____

Date _____ 20__ Time _____ AM __ PM __

Chairperson/Staff _____

| DATE | EXPLANATION/ REASON FOR CLAIM Describe union function attended | WAGES (See back of claim) | | TRAVEL (See back of claim) | | | MEALS | | | | FAMILY CARE (See back of claim) | | | HOTEL/ PHONE | MISC. EXPENSES Parking etc. | RECEIPTS ATTACHED | | ACCOUNTING USE ONLY |
|------|--|------------------------------|-------------|-------------------------------|----------------|-----------------|-----------|-----------|-----------|-----------------|------------------------------------|--------------|-----------------|-----------------|-----------------------------------|----------------------|----|------------------------|
| | | 804 | 802 | 702 | | | 704 | | | | 805 | | | 705 | | YES | NO | |
| | | Wages | Own Time | # of people | Kms. driven | Amt. (total) | B \$12 | L \$17 | D \$27 | Amt. (total) | From (hour) | To (hour) | Amt. (total) | | | | | |
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This expense report form is to be completed in full. Please type or print neatly.

Total + + + + =

Less advances

Was union leave required NO YES. If yes, attach supporting documentation confirming the details of time off without pay. SHIFT WORKER NO YES.

Signature _____ Date _____ 20__

Note: In order to avoid unnecessary delay in processing, please check to see that:
(a) this form is properly completed;
(b) all required receipts have been attached. Forward original copy to OPSEU.
Retain YELLOW copy for your records.

For Accounting use only

Account Number: _____

Balance owing to member (refund to OPSEU)

Authorized by chairperson/staff: _____

Payment approved by: _____

Date approved: _____

General Information

1. This form must be signed by the claimant and must be accompanied by the necessary original receipts (e.g. last portion of air fare, hotel bill/receipt.) Expense details should be listed chronologically and should include a brief description of the purpose/reason for the expense.

2. Claims must be submitted no later than ninety (90) days from the last date for which expenses are claimed and must be accompanied by a refund of the unused expense advance where applicable.

3. Any advances received should be deducted from the total expenses to arrive at the balance owing from/to OPSEU.

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Own Time/Wages

(a) Own Time will be paid to members using lieu days accumulated credits or vacation days. Own Time will not be paid for an unpaid day. Claims for Own Time must be accompanied by supporting documentation confirming the type of credit being used.

(b) Claims for lost wages must be accompanied by supporting documentation confirming the details of time off without pay.

(c) Shift workers must indicate exact hours of shift missed in order to properly calculate wages/childcare entitlement.

Note that advances are not deducted from wages or own time.

Meals

(a) Where a member/representative is on approved union business, he/she may be entitled to reimbursement for meals as per OPSEU policy.

Hotel/Phone (Accommodation)

(a) Where members are out of town on union business and/or an overnight stay is necessary, they are allowed to claim accommodation.

(b) Reimbursement will be made only for the hotel charges for room, tax and phone calls made on union business or otherwise allowed under the expense policy. Any other charges appearing on the hotel bill will not be reimbursed.

Travel

(a) A member will be reimbursed for the actual cost incurred for travel by public transportation. As per the policy of the Union, the most economical means of transportation should be used.

(b) The rental of automobiles must be approved in advance by the OPSEU Vice-President/Treasurer.

(c) Where members are required to use their private vehicles, they may claim for such travel at the current rate. The total distance travelled and destination points are to be indicated on the expense form.

(d) No reimbursement will be made for any expenses incurred where the appropriate prior authorization has not been obtained.

| KM | Name of Passenger(s) (please print) | Local Number |
|------------------|--|--------------|
| Single 50¢ | | |
| 1 passenger 55¢ | | |
| 2 passengers 60¢ | | |
| 3 passengers 65¢ | | |
| 4 passengers 70¢ | | |

Family Care (Child/Elder/Dependant)

Members are entitled to reimbursement of reasonable costs of family/dependant care provided by someone other than their partners /spouses as a result of absences from home arising from the conduct of union business. Such allowances are not intended to reimburse the claimant for dependant/family expenses that they would have normally incurred as a result of employment except where the absence exceeds the normal work day or week.

Family/Attendant care will be reimbursed at the rate of \$6.00 per hour to a maximum of 12 hours plus the overnight fee of \$40.00 to a maximum of \$112.00 per 24 hours period and must be signed by the care provider(s). Overnight is between the hours of 12:00 to 8:00 am, please specify hours claimed for each day.

Members who bring children to union events will be entitled to single accommodation and meal expenses. Claims for these expenses should also be included in the family care column of the form and described appropriately.

Important: please fill out family/attendant care claims (yellow and white separately)

| Family/Attendant Care Claims | |
|--|-------------|
| <i>Please complete for all family care claims (please print)</i> | |
| Care Provider | |
| Name | |
| Address | |
| City | Postal Code |
| Telephone | |
| Signature of Care Provider: _____ | |
| Children / Dependents | |
| Name | Age |
| Name | Age |
| Name | Age |
| Name | Age |
| Member confirmation <i>I affirm that without such family care I would have been unable to attend this OPSEU activity.</i> | |
| Signature: _____ Date: _____ | |