ADMINISTRATION MANUAL

OF THE

USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

Latest Revision: October 2020

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INTRODUCTION

This Administration Manual has been prepared to provide Employers with a set of procedures, which we believe, will ensure efficiency and economy of effort in the operation of the Plan.

NOTE: This Administration Manual does not constitute the terms of the Plan. For details in this respect please refer to the Text of the USW-Coastal Forest Industry Health & Welfare Plan

Throughout these procedures, reference is made to the forwarding of Enrollment Cards and Billing Forms, etc. "To the Administrator" or to the "Plan Office":

PLAN ADMINISTRATION OFFICE

The Trustees have retained Pacific Blue Cross to administer the Plan. The Plan address is:

USW-Coastal Forest Industry Health & Welfare Plan
c/o Pacific Blue Cross
PO Box 24715, Stn-F
Vancouver BC V5N 5T8

You may contact the Plan Office:

- by telephone at 604 419-2476;
- by FAX at 604 419-2884;
- by email at admn@pac.bluecross.ca ; or
- for most matters regarding enrollment, billing, claims, forms and supplies, call or email the Plan Office.
- if you wish to appeal an administrative decision, to bring something to the attention of the Trustees, or need a more in-depth explanation, ask to speak to the Plan Administrator.

NOTE: Your company may have a procedure whereby documents initiated at each location (or "Division") sent to the Company's Head Office, which will forward them to the Plan Office.

Even if this is true in your company, in matters regarding claims, the operating division should deal directly with the Plan Office.

***** PLAN OFFICE WEBSITE**: uswfi1.planoffice.ca ******

1. ELIGIBLE EMPLOYEES

An eligible employee is a person who is employed within the bargaining unit of a coast forest products operation and who is subject to the bargaining authority of Local Unions represented by United Steelworkers (USW) and whose employer is either a Regular or Benefits Only Member of Forest Industrial Relations Limited, and who is a regular full-time employee and who is regularly paid for thirty two (32) or more hours per week by that Participating Employer.

NOTE: Some employees continue to be eligible for full coverage under the plan even though they regularly receive less than 32 hours of paid employment each week. To qualify for this coverage, the employee must

- work four (4) or more days per week in a job category that existed prior to December 1, 1987; or

- work four (4) or more days per week in any job category, having been continuously employed in a four days per week job since November 30, 1987 or earlier.

If you are in doubt as to whether someone qualifies for coverage under this special category, contact the Plan Administrator.

NOTE: The Trustees have clarified the meaning of “regular full-time” employee as follows:

> “The employee has made himself available for full time work and is in a job which would be 32 or more hours per week if work was available.”

The first condition would exclude, for instance, employees who hold other jobs or attend school and as a result are not available full-time.

The second condition would exclude, for instance, employees hired only for week-end maintenance, unless it was one of the special weekend schedules which pay 32 hours per week or more.

2. EFFECTIVE DATE OF COVERAGE

Eligible employees as defined in Section 1, will have coverage and must enroll in the Plan on the date that the following requirements are met:

A. Any new employee who has not worked in covered employment in the last eighteen (18) months will be eligible to become a covered employee on the first day of the month following completion of thirty days worked within a ninety day period, provided he is then actively at work.

NOTE: If your collective agreement specifies a different qualification period, you must file the relevant section(s) of the agreement with the Plan Office.

NOTE: See exception for YOUR employees returning after more than 18 months under "C" below.

An employee shall be deemed to be actively at work on the first day of the month provided he is not then disabled, absent without leave or suspended and provided he worked his last regularly scheduled work day before the first day of the month.

NOTE: "Actively at Work" can include days off! For instance,

- new employee completes probation during the month
- works Friday 31st, normal days off are Saturday and Sunday
- although his next scheduled day of work is Monday 3rd, Saturday 1st, he is "actively at work" and covered.
- if in doubt, telephone the Plan Administration Office.

Should an employee not be at work as a result of being disabled, absent without leave or suspended on the first of the month when his coverage would otherwise have been effective, he shall become a covered employee on the date he returns to active employment.

B. Coverage is effective on the date you hire an employee who produces a Layoff and Transfer Card indicating that any time during the eighteen (18) month period immediately preceding the date he or she became an eligible employee with your Company, he last worked as a covered employee

- under the USW-Coastal Forest Industry Health & Welfare Plan

OR

- for a company that participates in either the Southern Interior Health and Welfare Plan or the Northern Interior Forest Industry Benefit Plan.

OR

- for the Northern Interior USW operations of Canfor Ltd.

OR

- for West Fraser Ltd.

NOTE: Should the employee not produce a Layoff and Transfer Card and you have reason to believe that he would be eligible for immediate coverage, email the Plan Office, who will check the records and advise you of the employee's status.

NOTE: EMPLOYEE LAID OFF BY ANOTHER USW-COASTAL PLAN EMPLOYER:

If the employee was entitled to either three or six months layoff coverage with another employer that participates in this plan, and this period has not yet expired, then:

i) Coverage will be continued by the previous employer, to the end of the month in which you hire him or her.
ii) Responsibility for coverage will shift to you on the first of the month following his or her employment with you, provided he or she is then actively at work with you. SEE NOTE under 2(A) above about "actively at work".
iii) If you subsequently lay off such employee, his or her remaining coverage will be the responsibility of the first employer.

NOTE: Where a new employee produces a Layoff and Transfer Card which indicates continuation of coverage with another employer which has not yet expired, you should return the Layoff and Transfer Card to the employee.

C. Where your employee with between 18 and 24 months of seniority retention under the Collective Agreement is called back to regular work with seniority remaining but has not worked in covered employment in the last 18 months, their benefit coverage will be reactivated from the employee's first day returned to work, but only (and retroactively) after they complete 10 working days within a floating period of 30 consecutive days.

D. Coverage is effective immediately upon return to the bargaining unit in the case of an employee who has previously been transferred by the Company to a supervisory position, or immediately upon return to work in the case of an employee who had been on leave of absence while appointed or elected to work full time for United Steelworkers (USW).

E. Coverage is effective immediately upon the date your Company becomes a member of Forest Industrial Relations Limited and the Coast Master Agreement, or another collective agreement providing for coverage under the USW-Coastal Forest Industry Health & Welfare Plan, is in force:

(i) provided his or her date of employment was prior to the month that the Coast Master Agreement became effective for your company, AND

(ii) provided he or she is then actively at work with you. SEE NOTE under 2(A) above about "actively at work".

It is possible an employee who does not qualify for immediate coverage under this section may in fact qualify, as a Transfer under 2(B) above. In that case, the employee would be covered under the provisions in 2(B) as soon as your Company becomes a member of Forest Industrial Relations Limited and the Coast Master Agreement is in force.

NOTE: Should you learn that a laid-off employee of yours has become employed by another employer that participates in this plan, please advise the Plan Administrator of the employee's name, social insurance number, and name of the new employer.

The administrator will confirm whether another employer is covering your laid off employee and will credit you for any overpayment.

For an explanation of employment of a laid-off member, see above under "NOTE: EMPLOYEE LAID OFF BY ANOTHER USW-COASTAL PLAN EMPLOYER".

3. ENROLLMENT

On the date an eligible employee is hired by you, the Enrollment Card (sample attached) should be completed as follows: This should be always done before he starts work, to ensure correct enrollment in the unlikely event of an accident on the first day. The Enrollment Cards (sample attached) must be completed as follows:

(a) Fill in the Name of Employer and, where appropriate, Division.

(b) Have the employee:

- Print full Name, Sex (male or female), Date of Birth and Social Insurance Number. It is extremely important that the Social Insurance Number be correct. (*) See note below on use of SIN.
- Print full Name of Beneficiary and Relationship of Beneficiary, as well as Beneficiary's address. Please note:

  - Each beneficiary's given name(s) and surname must be printed in full (e.g. "Mary Lou Smith", not "M. Smith", not "Mrs. John Smith").
  - If more than one Beneficiary is appointed, indicate the share, for instance, "My brother John Brown (40%) and sister Mary Best (60%)".
  - If the Beneficiary is a minor, the employee should name a Trustee, to avoid having the proceeds paid into court and held until a guardian is appointed. The Insurance Carrier recommends the following wording: "My daughter Melissa Brown, with my brother Keith Brown as Trustee on her behalf".
- Answer the question regarding any previous coverage under a USW - Forest Industry Health and Welfare Plan. This is extremely important. If the answer is "Yes" have the employee print his or her previous employer's Name and Division in the space provided.
- Date and sign the card in your presence.

(c) Witness the employee's signature.

(d) Enter the Actual Date of Employment in the space provided.

(e) Enter the "Effective Date of Coverage" (in accordance with Section 2).

(f) Initial "Checked by Employer" to indicate that you have checked the card for completeness and accuracy.

You should then complete the Employer Record Card (attached to Enrollment Card):

(g) Enter the Employee's Name (as on the Enrollment Card) and Social Insurance Number (after checking that the one on the Enrollment Card is correct). (*) See note below on use if SIN.

(h) Enter name of Beneficiary and Relationship. (You should have a procedure for recording any future Beneficiary changes. See Section 7 of these procedures.)

(i) Enter the Name of Employer and, where appropriate, Division.

(j) Enter the Effective Date of Coverage.

The Enrollment Card should now be detached from the Employer Record Card and both filed with any other new cards, in order of the month in which coverage is effective. The Enrollment Card should be forwarded to the Administrator, as outlined in Section 6 of these Administrative Procedures, and the detached Employer Record Card held in your office in a file of "Active" employees.

ENROLLMENT CARD "DOs AND DON'Ts"

DO:

☺ USE current enrollment cards
☺ INSIST employee complete it before starting work
☺ CHECK that he has completed it properly
☺ CHECK that he has dated the card and signed it in your presence
☺ WITNESS his signature

DON'T:

☹ USE old stock of enrollment cards
☹ GIVE blank card to new employee and hope he'll fill it in and return it "someday"
☹ ACCEPT an incomplete card
☹ ACCEPT a card if the beneficiary has signed as witness

USE OF SOCIAL INSURANCE NUMBER:

By signing the enrollment card, enrolling employees authorize the use of their social insurance number for Plan administration.

If an employee refuses to give this authorization he should cross out that sentence ("I hereby authorize...") and initial the change. Leave the "Social Insurance / ID No." blank, and Pacific Blue Cross will provide an alternative 9-digit number. The member should be informed in such cases that the alternative number must be used for all claims under the Plan, and also the SIN must still be provided for any weekly indemnity (WI) claims, as WI is a taxable benefit.

In such cases, you should wait for the identification number from Pacific Blue Cross, and use it on the Employer Record Card in place of SIN. This identification number must then be provided in all correspondence about the employee.

4. TERMINATION OF COVERAGE

An employee will cease to be covered by the Plan from the earliest of the following dates:

(a) The date employment is terminated, provided the terminated employee is not then in receipt of the weekly indemnity benefit from the Plan OR on Workers' Compensation wage loss claim or WCB income continuity.

(b) The exact date the employee is laid off, PROVIDED he or she has less than four months' seniority.

NOTE: "Laid Off" has been defined by the Trustees, taking into account the legislative requirement that an ROE must be issued after 7 days "without work or insurable earnings". Therefore:

- If a covered "probationary" employee has worked within 7 calendar days, for purposes of this Plan, including WI entitlement and employer contributions, he would be considered not laid off and therefore covered.
- On the eighth day without work, unless the employee is disabled or deceased, coverage ends retroactive to the first day laid off.

(c) Three months from the exact date the employee is laid off, PROVIDED seniority is more than four months but less than one year.

(d) Six months from the exact date the employee is laid off, PROVIDED seniority is one or more years.

NOTE: Coverage, and therefore contributions required under the Plan for those laid-off employees entitled to layoff coverage as in (c) or (d) above may cease before the expiration of the three to six month period. Coverage stops on the date that:

(i) an employee is terminated under 4(a) above, OR

(ii) an employee notifies you that he or she has terminated his or her employment with you, OR

(iii) an employee is covered by another Employer, as outlined in Section 2(B) of these Administrative Procedures.

(e) The date the employee is granted Workers' Compensation pension for permanent and total disability.

(f) The date following expiry of twenty-six weeks' payment of the weekly indemnity benefit provided the employee does not immediately return to active employment.

NOTE: if a member's coverage is terminated under (e) or (f) above, he may be eligible for benefits under the IWA-FI LTD plan. Also, he may be eligible for continuation of life insurance (see "How Benefits Continue..." at the end of this section).

NOTE: When an employee is absent from work on lay-off coverage and subsequently goes on claim under the Plan, coverage will continue for the period the employee is in receipt of the weekly indemnity benefit from the Plan, OR for the period of his or her lay-off coverage, WHICHEVER IS LONGER.

NOTE ON CONTRIBUTIONS: For Plan Administration purposes it is important to know the exact date of an employee's termination of coverage as outlined above. However, contributions must be paid for the whole month for all employees covered on the first of the month, even if they are later terminated (See Section 6).

NOTE ON LIFE INSURANCE: A terminated member has a 31 day grace period to convert to an individual policy (see "LIFE INSURANCE CONVERSION" on page 13). Life insurance remains in effect for these 31 days.

TERMINATION OF COVERAGE CARD

When an employee's coverage is terminated, the Termination of Coverage Card (sample attached) should be completed, showing Date of Termination of Coverage (i.e. the last day worked), the reason for termination and Name of Employer, dated and signed. The Termination Card for an employee whose coverage is terminated should be forwarded with the billing for the month immediately following the month in which the termination is effective.

LAY-OFF AND TRANSFER CARD

A covered employee whose employment is terminated or who is laid off, must be given a Layoff and Transfer Card (sample attached).

This Layoff and Transfer Card covers both the USW-Coastal Forest Industry Health & Welfare Plan and the Basic Medical coverage provided by the employer under the Medical Services Plan of B.C.

COMPLETION OF THE
USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN
PORTION OF THE LAYOFF AND TRANSFER CARD

(i) Enter full Name of Employee, Social Insurance Number (or I.D. number - see “Enrollment”) and last day worked.

(ii) Check the appropriate box to show whether the employee is terminated, laid off with no extension, or laid off with 3 or 6 month extension.

(iii) Fill in date Health and Welfare contributions will be paid to, which will be Date of Termination or Lay-off (or three months or six months from the date of lay-off).

(iv) Complete the Medical Care portion of the card.

(v) Enter Employer’s Name and Division on the Medical Care portion of the card.

(vi) Date and sign the Medical Care portion of the card.

The card should then be handed to the employee with the request that he or she safeguard it carefully for presentation upon re-employment or upon employment elsewhere.

NOTE: THIS LAY-OFF AND TRANSFER CARD IS AN IMPORTANT DOCUMENT IN THE ADMINISTRATION OF THE PLAN, AS IT PROVIDES PROOF, BOTH TO THE EMPLOYEE AND TO ANY NEW EMPLOYER, OF THE CORRECT STATUS OF THE EMPLOYEE UNDER THE PLAN.

LIFE INSURANCE CONVERSION

An employee whose Group Life Insurance coverage is terminated has the right to convert to an individual policy without medical evidence of insurability. To exercise this right, he must make proper application to the British Columbia Life & Casualty Company (BC Life) and pay the appropriate premium within 31 days from the date of termination of his Group coverage. Those interested should be given a completed "Group Life Conversion Privilege Notification" (sample attached) and should be advised to consult with a financial security advisor to convert their group life coverage. This will help ensure they receive the professional advice required to make informed decisions when applying for individual life insurance.

This can be a very valuable option, especially for someone not in good health, and employees should be reminded of their right. Someone in good health, particularly a non-smoker, should find out if they would qualify for a lower rate based on medical evidence.

The Life insurance coverage is deemed to be in effect during the 31-day grace period.

GROUP LIFE INSURANCE CONVERSION IS:

- ☞ VALUABLE if not in good health
- ☞ AVAILABLE to ALL employees whose coverage ends:
  - normal retirements
  - disabled, on reaching age 65
  - not or no longer disabled under terms of the LTD plan, but prevented by disability from returning to former employment
  - other employees on long lay-off

HOW BENEFITS CONTINUE FOR DISABLED EMPLOYEES

Full benefits under the Plan continue for disabled employees while receiving weekly indemnity (WI) or WCB wage loss or WCB income continuity benefits. You must continue to make monthly contributions on behalf of such employees.

Once the WI or WCB wage loss or income continuity benefits end and if the employee continues to be totally disabled, his life insurance will be maintained to age 65 or until he recovers. You are not required to pay monthly contributions on behalf of such employees.

Life insurance will be maintained automatically while the employee is in receipt of benefits from the LTD plan. If his LTD benefits end prior to age 65, and he remains totally disabled, he will be asked to have his doctor complete a physician's statement so that a decision can be made as to whether or not coverage should continue to age 65. The employee must provide satisfactory proof of disability to the Trustees when requested.

NOTE: If the employee is still disabled after receiving WCB benefits for more than 52 weeks, the Plan will not be aware of his situation unless you notify us. Please see Section 9(b) of this manual (Continuation of Life Insurance Benefit), and also Section 6 (Billings and Remittance).

LIFE INSURANCE CONTINUATION FOR DISABLED MEMBERS IS:

- AUTOMATIC if on LTD
- BUT MEMBER MUST APPLY if not on LTD

DISABLED EMPLOYEES (Non-occupational & Occupational Claims)

1) Non-Occupational - Member is injured off the job or suffers a non-occupational illness (including ICBC and other 3rd party claims):

Period of disability	Employee's Benefits	Employer's Contribution
Weeks 1 – 26	WI, Life, & AD&D	normal rate
Weeks 27 to recovery or age 60 while on LTD	WI & AD&D benefits cease Life continues under a Waiver (USW-Coastal FI Plan)	nothing
Age 60 - age 65	Life Waiver (USW-Coastal FI Plan)	nothing

2) Occupational (WCB) - Member is injured on the job:

Period of disability	Employee's Benefits	Employer's Contribution
Weeks 1 – 52*	WI, Life, & AD&D	normal rate
Weeks 53 - PPD	WI, Life, & AD&D	nothing
PPD to recovery or age 60 while on LTD	WI & AD&D benefits cease Life continues under a Waiver (USW-Coastal FI Plan)	nothing
Age 60 - age 65	Life Waiver (USW-Coastal FI Plan)	nothing

There is an important distinction between a non-occupational claim versus an occupational claim.

Non-occupational (including 3rd party) claims have a maximum duration of 26 weeks in which Employer contributions must be remitted for the full duration.

Occupational or Workers Compensation (WCB) claims have no set duration and coverage must continue while the claimant is receiving either temporary wage loss or income continuity. Recognizing the possibility of a lengthy claim duration, the Plan has capped the maximum required contributions at 52 weeks. Coverage can then continue under a waiver until the point of recovery or the WCB wage loss transitions to a WCB pension.

PERMANENT CLOSURE

Normally, coverage under the Plan ends on the date of permanent closure. However, employees disabled on the date of permanent closure continue to be covered under the terms of the Plan (see above, "How Benefits Continue...") without the requirement of employer contributions.

5. LAY-OFF

An employee, who has less than four months' seniority at the time he is laid off, is NOT entitled to lay-off coverage. For purposes of the Plan, the employee should be treated as having terminated employment.

NOTE: see the interpretation of "Laid Off" for employees without seniority above under "4. TERMINATION OF COVERAGE".

If the laid-off employee has more than four months but less than one year seniority, coverage will continue for three months following the date he was laid off. The employee must continue to be included as a covered employee on the billing forms and contributions must be reported and remitted for him in each of these three months.

If the laid-off employee has one or more years' seniority, coverage will continue for six months following the date he was laid-off. You must continue to include the employee as a covered member on the billing forms and contributions must be reported and remitted for each of these six months.

NOTE: coverage for benefits under the Plan end on the EXACT date given, that is on the date of lay-off, or after a 3- or 6-month extension. This should not be confused with Dental and EHC coverage, which always run to the end of the month. Study the "LAYOFF COVERAGE EXAMPLES" on the next page.

The Employer Record Card for a laid-off employee whose coverage is continued, should be removed from the file of "Active" employees and filed with those of other laid-off employees, in order of the month in which coverage will terminate. Upon termination of coverage, the Termination of Coverage Card should be forwarded with the billing for the month immediately following the month in which the termination is effective.

EXTENSION OF LAYOFF COVERAGE

If an employee is recalled from layoff during the period in which he has layoff coverage, and returns to work for at least one (1) working day and less than ten (10) working days in a calendar month, his layoff coverage is extended by one month.

REINSTATEMENT OF LAYOFF COVERAGE

Layoff coverage is fully reinstated if an employee returns to regular full time employment for ten (10) working days within a floating period of thirty (30) consecutive days.

LAYOFF COVERAGE EXAMPLES

Member with 2 years seniority is laid off January 8.
Lay off extension is until July 8.

Member returns to work March 7, 8, 9.
- This “buys” coverage for March
- Lay-off extension is now until August 8

Member does not return to work before August 8
- Coverage terminates August 8.
- Contributions are due through August, even though the member is not covered for August 8 - 31.

Member works September 12, 13, 14
- Coverage starts September 12
- Coverage terminates September 30
- Contributions are not due for September because the member was not covered on September 1.

Member works October 24 - November 2
- Coverage starts October 24
- Coverage terminates November 30, the end of the calendar month of layoff.
- Contributions are not due for October, because member was not covered on October 1, but they are due for November.

Member works December 5 - December 20
- By working 10 or more days in 30, the member’s layoff coverage is reinstated.
- Coverage starts December 5
- Contributions are due for January and subsequent months while the member remains covered.
- Layoff extension is now until June 20.

6. BILLINGS AND REMITTANCE

When your company joins the USW- Coastal Forest Industry Health & Welfare Plan, you should immediately send in enrollment information for your employees who are qualified for coverage, as described in Sections 1 - 3 of this manual.

At the beginning of each month, the Plan Office will send you a bill listing all currently covered employees (sample attached). This will include the contributions due for your covered employees for that month, and any credits or additional charges for prior months. This will include all changes received by the Plan Office up to the time the bills are produced, usually the 23rd of the preceding month.

Please Pay as Billed

Please check your monthly bill carefully, especially to ensure that any changes you sent to the Plan Office since the last bill have been correctly shown.

When you receive your monthly bill, you may have changes in progress, such as

- enrolments,
- terminations, or
- changes of coverage from full to lay-off coverage or vice versa,

Either you have submitted these to the Plan Office but they have not yet appeared on the bill, or you know about the changes and are about to submit them.

Or, possibly a change not reflected on the billing has gone astray. If you think that may have happened, please contact the Plan Office immediately, and if necessary send the information again.

Regardless, please “Pay as Billed” and wait for the credits or extra charges to appear on your next monthly bill. By doing so, you keep the reconciliation simpler for both your office, and for ours.

INTEREST IS CHARGED ON LATE PAYMENTS AS STATED IN YOUR PARTICIPATION AGREEMENT.

GST

Effective July 6, 1992, the Plan is registered as a GST supplier, with registration number R131687105. From that date, a portion of the monthly contributions to the Plan is allocated to GST and you may claim an input tax credit on it. Effective April 1, 2013, the GST rate is 5%.

Regardless of your monthly contribution rate, there is a GST component of $0.75 per enrolled employee per month. The GST is averaged across all employees,

whether fully covered or on Leave of Absence. The Plan's GST registration number is #R131687105.

For instance, if you have 80 covered employees in a month, your input tax credit for that month is 80 x $0.75 = $60.00.

7. CHANGE OF BENEFICIARY

When an employee wishes to change his or her beneficiary, he should complete the "Change of Beneficiary Under the Plan" form (sample attached) in duplicate. Both copies must be dated and signed by the employee and by a witness to his or her signature.

- The same recommendations about beneficiaries which are noted in the section on "Enrolment" should be followed for Change of Beneficiary.

Forward both copies of the Change of Beneficiary Form to the Administrator. One copy of the Change of Beneficiary Form will be returned to you confirming the change of beneficiary.

8. CHANGE OF NAME OF EMPLOYEE OR NAME OF BENEFICIARY

Where applicable, the "Change of Name Under the Plan" form (sample attached) should be completed in duplicate as follows:

(i) Print Employer's Name and Division

(ii) Print Employee's Name and Social Insurance Number. (or I.D. number - see "Enrollment")

(iii) Indicate whether name change is for the employee or beneficiary.

(iv) Print current name of employee or beneficiary.

(v) Print new Family or Surname and Given or First names.

(vi) Indicate reason for change and attach any applicable documents.

(vii) Have employee date and sign card and ensure that employee's signature is witnessed.

When fully completed, forward both copies of this form together with any other relevant documents to the Administrator who, upon receipt, will register the change and return one copy to you.

9. CLAIMS

Claims for the Weekly Indemnity, Accidental Death and Dismemberment and Life Insurance benefits are to be filed with the Administrator in accordance with the following instructions.

Notification of each claim submitted is to be sent to the office of the Local Union on the form provided for that purpose (sample attached). A copy of the Union Notification must be attached to the claim form when the claim is submitted to the Administrator.

(A) WEEKLY INDEMNITY BENEFIT

When a claim is to be made for this benefit, the form headed "USW-Coastal Forest Industry Health & Welfare Plan Claim for Weekly Indemnity Benefits" (sample attached), should be fully completed by the employee, employer, and attending physician. To eliminate delay in the payment of the benefit, it is essential that this form be correctly and fully completed. When this has been done please mail direct to the Administrator, attached to a copy of the Union Notification Form.

From time to time the Claims payer BRITISH COLUMBA LIFE AND CASUALTY COMPANY (BC LIFE) may require completion of an "Attending Physician's Supplementary Statement" before further payments will be made.

The Trustees of the USW-Coastal Forest Industry Health & Welfare Plan may request an Independent Medical Examination of the employee by a physician of their choosing.

NOTE: (i) If there is a possibility that there will be a delay in the submission of the claim form, then written notice must be given to the Administrator within 20 days from the commencement of the disability and the completed claim form forwarded within 90 days from the date of disability.

Failure to submit notice of claim or the claim form within the specified period shall not invalidate the claim if a written reason for the delay is submitted and that reason is acceptable to the Plan Trustees.

(ii) Weekly Indemnity payments do not commence until the end of a vacation period when the disability commences during the time an employee is on regular vacation.

However, if a disability commences prior to a vacation period, the Master Agreement provides that the employee

be granted leave of absence while disabled and he or she cannot take, or be given, regular vacation during that time.

Consequently, Weekly Indemnity payments which commenced before a shift, plant or operation shut-down for holidays will continue through the vacation period (so long as the employee continues to be disabled).

(iii) Weekly Indemnity benefits are not paid if a member becomes disabled while he or she is on a Compassionate Leave of Absence for reasons other than Apprenticeship Training under an approved provincial apprenticeship program. Following the last day of the Compassionate Leave of Absence, the member may be eligible for weekly indemnity benefits if he or she is disabled and had either returned to British Columbia or is hospitalized.

(iv) On the day the employee returns to work a "Return to Work Notice" (sample attached) should be completed by you and mailed direct to the Plan Administrator.

A copy of the "Return to Work Notice" is to be mailed to the Local Union Office.

Should a Weekly Indemnity payment be received covering a period which is subsequent to an employee's return to work then the payment should be returned direct to BC LIFE.

REIMBURSEMENT AGREEMENT - WCB CLAIMS

The Text of the USW-Coastal Forest Industry Health & Welfare Plan stipulates that Weekly Indemnity benefits will be paid for disabilities caused by "a non-occupational accident or non-occupational illness". However, in those cases where the Workers' Compensation Board has not reached a decision within four weeks of the date on which a full and proper claim was filed with them, or where an appeal is being filed subsequent to the declination of a claim by the Board, or if the member's Doctor determines his injury or illness to be of a non-occupational nature, it is possible for a covered employee to receive Weekly Indemnity benefits under the Plan, subject to approval by the Trustees and repayment by the employee, if the Workers' Compensation claim is subsequently approved.

To claim benefits under these circumstances:

(i) A full and proper claim must have been filed with Workers' Compensation Board at least four weeks prior to the date on which the claim for Weekly Indemnity benefits is being submitted, and the WCB has not made a decision, or

the member's claim for benefits has been disallowed by the WCB and either an appeal has been filed or the member's physician agrees the disability is not work related.

(ii) A Reimbursement Agreement (sample attached) must be completed by the employer who agrees to inform BC Life & Casualty Company (BC Life) immediately if a decision is reached by the Board and by the employee who agrees to reimburse BC Life for the full amount of Weekly Indemnity benefits paid.

(iii) The Union Notification of Claim must indicate that a Workers' Compensation Board claim has been filed.

NOTE: When weekly indemnity benefits are paid to an employee who has filed a WCB claim, the six-day waiting period applies, regardless of whether the disability is an injury or an illness.

REIMBURSEMENT AGREEMENT - THIRD PARTY CLAIMS

Members claiming weekly indemnity for a disability where a third party may be liable must complete a "Reimbursement Agreement" (sample attached) in order for their claim to be processed. In most cases, this would involve a motor vehicle accident for which an ICBC claim may be made, but it includes any disability for which a third party is responsible. The completed agreement should be sent in with the claim form, to avoid processing delays. Affected claimants will also be sent an accident report form for completion by the member (this is not a police report form). This will not delay initial payment(s) for a claim, but the report should be returned promptly to avoid delays in further payments.

Although the wording of the Reimbursement Agreement is general, recovery by the Plan will be defined in the Memorandum of Agreement signed February 11, 1992, which may be less than the amount of WI paid.

STATUTORY HOLIDAYS

The Letter of Understanding of May 22, 2001 governs how statutory holidays during a WI claim are treated, and since then, the Plan has been administered in accordance with that LOU. The intent is to ensure disabled members are compensated for statutory holidays occurring during disability, either by payment of wages or payment of WI benefits, while avoiding duplication of payment.

WI Claim up to 90 days: If a disabled member returns to work from an absence of 90 days or less, normally the employer must pay for any statutory holidays in that period. Therefore, BC Life should be recovering the stat holidays paid. If BC Life knows of the return to work in advance, they will reduce the final disability cheque by the number of statutory

holidays for which the member will be paid upon return. If they are advised of the RTW date after the final disability cheque is issued, the member must reimburse BC Life for those days.

NOTE: In some cases, possibly when the member had not worked immediately prior to the onset of disability or does not return to work at the end of the claim, even though the claim is under 90 days, he or she does not receive pay for statutory holidays in the claim period. If that happens to an employee, it does not affect the above rule; BCL Life still deducts the statutory holidays from the claim period. The Trustees may consider forgiving the deduction upon appeal, depending on the circumstances.

WI Claim over 90 days: If the disabled member does not return to work within 90 days, the employer does not pay for any statutory holidays in the disability period, so there is no overpayment for BC Life to recover.

GRADUATED RETURN TO WORK

The purpose of this voluntary program is to help disabled employees return to the jobs they held before becoming disabled.

It involves a return to work on a part-time basis when the member and the doctor agree that the member is ready. The employer, local union, disabled member and a rehabilitation counselor develop a modified work schedule which increases until the member can return to work full-time.

Normally a reduced number of hours is worked each day, but the agreed schedule may involve a reduced number of days each week, until the member is working full-time.

Disabled members who participate in the graduated return-to-work program continue to receive full WI benefits until the member's full time hours are reached. In addition, the employer tops-up the hourly wage up to the full rate.

(B) CONTINUATION OF LIFE INSURANCE BENEFIT

If, at the expiration of Weekly Indemnity benefits (i.e. 26 weeks) or, in the case of an occupational disability, on the date a permanent disability pension is granted by Workers' Compensation Board, a covered employee is still TOTALLY disabled, his or her coverage must be terminated. However, the member may be eligible for continuation of Group Life Insurance to age 65. The amount of life insurance shall be that for which the employee is covered as of the last day for which premium is payable.

Enrollment for this benefit is automatic when the member applies for, and receives, Long Term Disability. For other members, Application for

Continuation of Life Insurance forms are available from the Plan Administrator. These are sent to members when necessary.

NOTE: Because the Plan pays WI benefits, the Plan office can identify all members completing 26 weeks on WI and ensure they have an opportunity to apply for Life Insurance Continuation if not accepted on LTD. HOWEVER, if a member receives 52 or more weeks of WCB Wage Loss and /or WCB Income Continuity before receiving a PPD pension, the Plan HAS NO WAY OF KNOWING UNLESS YOU, THE EMPLOYER, TELL US *(for more details, refer to page 13)*.

PLEASE, when terminating coverage for a disabled member, ALWAYS indicate his situation on the back of the Monthly Billing Form (under Termination Date and reason), so that we can send the necessary application form.

Please refer to "How Benefits Continue for Disabled Employees" under Section 4 (Termination of Coverage).

(C) CPP DISABILITY BENEFITS

When an employee has been in receipt of WI benefits for 90 days, a copy of the Canada Pension Plan's "Disability Benefits" pamphlet, with a covering letter, is enclosed with his next cheque. Of course, not all disabled employees should apply for these benefits at that time. Only a small fraction of WI claimants reach 26 weeks on claim, and fewer still are permanently disabled.

However, if in the judgment of the employee and his physician the disability is severe and likely to be prolonged, an early application for CPP Disability Benefits may help to assure him of future income.

CPP Disability Benefits, payable to qualified employees from the fourth month after disability, do not reduce Weekly Indemnity payments, although they are integrated with any LTD benefits the employee may later qualify for. In addition, receipt of CPP benefits while the employee is unable to work ensures the maintenance of eventual CPP Retirement Benefits.

If the employee wishes to apply for CPP Disability benefits, he must telephone to make an appointment at the nearest Canada Pension Plan office. Their number is in the blue pages of the telephone directory. If the disability prevents the employee from going in for an appointment, Health & Welfare Canada will arrange to go to the employee.

(D) DEATH BENEFIT

When a claim is to be made for this benefit, the BC Life form headed "Life Insurance & Accidental Death Claim Form" (sample attached) must be completed fully by all parties concerned (Employer and Beneficiary /Claimant). An original or notarized copy of the Death Certificate or Funeral Parlour Certificate should be included with the claim.

When the insurance is payable to a named beneficiary, the insurance company can release all proceeds payable when it receives the completed "Life Insurance & Accidental Death Claim" form, and the original or notarized copy of the death certificate.

If the Estate has been named the beneficiary, or if no beneficiary has been named, or if the named beneficiary has died and no new beneficiary was named the insurance will be paid to the Estate. In such cases the following additional documents are required: Probated Last Will and Testament of the deceased, and Letters of Administration.

Should the beneficiary be a minor under 19 years of age the benefit can be handled in the following two ways:

(i) The money can be paid to a Guardian of the Estate of the Minor, in which case a notarized copy of Letters of Guardianship will be required.

(ii) The money can be paid to the Public Trustees.

<u>DEATH CLAIM REMINDERS</u>

- Life Insurance & Accidental Death Claim forms are to be completed by the employer and beneficiary/claimant. An original or notarized copy of the Death Certificate or Funeral Parlour certificate should be submitted with the claim form.
- Accidental Death: Additional information is required, e.g. coroner's report and newspaper clippings.
- Missing Persons: beneficiary or estate must apply to the courts for "presumption of death". There is usually a lengthy waiting period before this can be issued.

ADVANCE - TERMINAL ILLNESS

The insurance carrier will advance up to half (50%) of the Group Life Insurance Benefit amount in the event of terminal illness, with a life expectancy of one year or less.. Financially, the advance works as a loan against proceeds of the life insurance, so upon death, the estate or named beneficiary will receive a residual amount after deducting the advance plus interest.

If an employee wants an advance on his/her life insurance, he/she should contact the Plan administration office, or someone should do so on his/her behalf and ask for an application form "Living Benefit Claim Form" (sample attached). Attached to this application form is an "Attending Physician's Statement – Advance Payment Request" form for the applicant's Doctor to complete.

(E) ACCIDENTAL DISMEMBERMENT BENEFIT

Should the death be due to an accident, the same "Life Insurance & Accidental Death Claim" form is used as the Group Life Insurance Benefit. When the form has been completed fully, it must be mailed to the Administrator, attached to a copy of the Union Notification form. For accidental death claims, additional information is required -- Coroner's report (sample attached) and newspaper clippings would suffice.

10. TAXATION

Tax Status of Plan Benefits

The premiums paid by the Plan on the members' behalf for Group Life insurance are a taxable benefit to the employee. The Plan office will notify you towards the end of each year of the monthly taxable benefit for the coming year. This is to allow your payroll system to accrue the taxable benefits for each employee for each covered month, for reporting on the T4 you issue each year-end.

The Basic Medical (MSP-BC) premiums you pay on an employee's behalf, which are not a part of this Plan, are also a taxable benefit and should also be included in the T4s.

STD benefits are also taxable income. Employees who receive STD Benefits in a year will receive a T4A from BC Life for those payments at year-end. If the employee later repays BC Life due to a successful WCB or third party (e.g. ICBC) claim, he or she will receive an adjustment letter for the repayment from BC Life.

Calculation of Taxable Benefits

You may notice that rate of Taxable Benefit changes from year to year even when the monthly contribution rate is unchanged, and that the amount of taxable benefit is different from the amount paid for people on Leave of Absence. The LOA rate also includes estimated AD&D costs, but that's only a small part of the difference.

Of course, there are other components to the monthly contribution, but the Group Life Insurance portion is only an *estimate* of the expected future cost of life insurance, based on the plan's demographics and past claims experience.

As is common with large groups, the financial arrangements with the insurance carrier are negotiated so that adjustments are made for actual experience. That helps us keep overall costs as low as possible by essentially sharing the risk with the insurance carrier.

In accordance with the tax regulations as they apply to this kind of plan, the amount of taxable benefit is calculated by applying the actual costs per employee for the most recent complete contract year to the benefit levels of the coming year. This means that depending on the number of deaths in the past year, the taxable benefit for the coming year can change significantly even though there is little or no change in the monthly contribution rate.

11. FURTHER INFORMATION

For further information on the Plan please refer to the "Text of the USW-Coastal Forest Industry Health & Welfare Plan" or contact your Head Office or the Plan Office (contact information for the Plan Office is in the INTRODUCTION section of this manual).

12. SAMPLE DOCUMENTS

1. Sample Invoice 28
2. Enrollment / Termination card 30
3. Change of Beneficiary card 32
4. Change of Name card & Transfer card 33
5. Union Notification of Claim form 34
6. BC Life Short Term Disability Claim form 35
7. Return to Work Notice form 37
8. Notice of Leave of Absence 37
9. WCB Reimbursement Agreement 38
10. Life Insurance Conversion Options letter 39
11. BC Life – Conversion from Group Term Life form 40
12. BC Life – Life Insurance & Accidental Death Claim form 41
13. BC Life – Living Benefit Claim form 45

bh:chwdadm
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1. Sample Invoice

Trustees of the USW - Coastal Forest Industry Health & Welfare Plan[1]
c/o Pacific Blue Cross PO Box 24715, Stn. F, Vancouver, BC V5N 5T8
☎: 604 419-2476 FAX: 604 419-2884 Email: admn@pac.bluecross.ca Web:http://uswfi1.planoffice.ca/

ABC LOGGING LTD
1234 MAIN STREET
NANAIMO, BC V1V 2E3

Account Code : 12345BA
Invoice # : C30934
Invoice Date : 08/16/16
Coverage Per : 08/01/2016-08/31/2016

I N V O I C E S U M M A R Y

Balance	0.00
Payments	0.00
Current Activity	101.19
Misc Charges (Interest, Adjustments, Lost Discounts)	0.00
Amount Due	101.19

Make cheque payable to : USW-Coastal H&W Plan
Questions? Call : 604-419-2476

SAMPLE

Return this portion with your payment

ABC LOGGING LTD
1234 MAIN STREET
NANAIMO, BC V1V 2E3

Account Code : 12345BA
Invoice # : C30934
Invoice Date : 08/16/16
Coverage Per : 08/01/2016-08/31/2016

Amount Due 101.19

Payment Enclosed ----------

(1) formed by the merger of the USW-Forest Industry Health & Welfare Plan No. 1 and USW-Forest Industry Health & Welfare Plan No. 2

Trustees of the USW - Coastal Forest Industry Health & Welfare Plan[1]
c/o Pacific Blue Cross PO Box 24715, Stn. F, Vancouver, BC V5N 5T8
☎: 604 419-2476 FAX: 604 419-2884 Email: admn@pac.bluecross.ca Web:http://uswfi1.planoffice.ca/

ABC LOGGING LTD
1234 MAIN STREET
NANAIMO, BC V1V 2E3

Account Code : 12345BA
Invoice # : C30934
Invoice Date : 08/16/16
Coverage Per : 08/01/2016-08/31/2016

Id Number	Name	Begin Dt	End Dt	FULL	LOA	HST	SCHG	BOM	Waiver	Total
XXXXXX123	DOE,JOHN	08/01/16	08/31/16	97.25	0.00	0.75	0.00	3.19		101.19
Discounted Current Amount Due				97.25	0.00	0.75	0.00	3.19		101.19
Current Activity				97.25	0.00	0.75	0.00	3.19		101.19

(if paid by end of month)

See invoice summary for total amount owing

PAYMENT IS DUE BY THE END OF THE MONTH INVOICED. TO ENSURE PROPER ADMINISTRATION OF THIS PLAN, PLEASE REMIT THE PAYMENT IN FULL AS BILLED. PAYMENTS, ADDITIONS, TERMINATIONS AND OTHER CHARGES RECEIVED BY THE 23RD WILL BE REFLECTED ON NEXT MONTH'S INVOICE.

REMIT YOUR CHEQUE WITH THE ATTACHED PAYMENT SLIP DIRECTLY TO THE PLAN OFFICE AT THE ADDRESS SHOWN ABOVE.

Benefit Plan Totals

USWFULL	USWLOA	USWHST	USW3CHG	USWBOM
2	0	0	0	2

Current Member Totals

USWFULL	USWLOA	USWHST	USW3CHG	USWBOM
1	0	0	0	1

(1) formed by the merger of the USW-Forest Industry Health & Welfare Plan No. 1 and USW-Forest Industry Health & Welfare Plan No. 2

2. Enrollment / Termination Card

1/2

USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

ENROLLMENT CARD BENEFICIARY DESIGNATION

Name of employer			Employer Account Code
Division name			Local
Employee's last name (print)	First name	Middle name	
☐ Male ☐ Female	Date of birth (mm-dd-yyyy)	Social Insurance Number/ID number	
Name of last employer if you were covered by this Plan or another USW-Forest Industry Plan		Employer Account Code	

I DESIGNATE AS REVOCABLE BENEFICIARY IN THE EVENT OF MY DEATH

Name (Last, first, middle initial)	Relationship	Share	Important notes
		%	If you name more than one beneficiary, show percent share of preceeds for each.
		%	**IF BENEFICIARY IS A MINOR, NAME A TRUSTEE ON HIS/HER BEHALF** (turn over this form).
		%	

I AUTHORIZE the use of my Social Insurance Number for plan administration and group insurance purposes.
I AUTHORIZE any person or organization to release and exchange records or knowledge of me and my beneficiaries to the Trustees of the USW- COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN. and their administrators and insurance carrier(s) as necessary for the purposes of benefit enrollment, administration of the insurance contract, and any subsequent claim. I authorize the same parties to consult the files they already hold concerning me for such purpose.

Employee's signature	Witness signature	Date (mm-dd-yyyy)

EMPLOYER SECTION

Date of hire (mm-dd-yyyy)	Qualifying period date (e.g. 30th day worked) (mm-dd-yyyy)	Effective date of coverage according to Plan rules (mm-dd-yyyy)	Employer signature

USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

EMPLOYER RECORD & TERMINATION OF COVERAGE CARD

Employee's name		SIN / ID number	Effective date of coverage (mm-dd-yyyy)
Name of employer			Employer number
Division name			Local
Name(s) of beneficiary(ies)		Relationship(s)	

Date of Layoff	Returned to work	Date of Layoff	Returned to work	Date of Layoff	Returned to work

Coverage terminates upon termination of active employment except as provided by the Plan.	Date of termination of coverage (mm-dd-yyyy)
Reason for termination ☐ Quit ☐ Retired ☐ Dismissed ☐ End of lay-off coverage ☐ End of short term disability period ☐ Deceased ☐ Other:	
I confirm a transfer card has been issued to the employee whose name appears above.	

Employer representative's name	Signature	Date (mm-dd-yyyy)

0572.001 52-20-401 02/14 CUPE 1816

Enrollment / Termination Card

USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

ENROLLMENT CARD BENEFICIARY DESIGNATION

TRUSTEE APPOINTMENT FOR MINOR BENEFICIARY(IES) UNDER AGE 18

I appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary who is a minor at the time of payment, money payable to the beneficiary under this Plan.
(**If minor beneficiary lives in Quebec:** this form may not be valid; please seek legal advice on how to designate a trustee for a minor beneficiary in Quebec).

Full Legal Name of Trustee	Relationship to member
Trustee email address	**Trustee phone number**

Other Trustee notes/contact information

Employee's signature	Witness signature	Date (mm-dd-yyyy)

3. Change of Beneficiary Card

USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN **CHANGE OF BENEFICIARY**

Name of employer		Employer Account Code
Division name	Local	Social Insurance Number/ID number
Employee's last name	First name	Middle name

I revoke the appointment of any existing beneficiary under the USW-Coastal Forest Industry H&W Plan AND DESIGNATE THE FOLLOWING AS REVOCABLE BENEFICIARY IN THE EVENT OF MY DEATH:

Name (Last, first, middle initial)	Relationship	Share	Important notes
		%	If you name more than one beneficiary, show percent share of preceeds for each. **IF BENEFICIARY IS A MINOR, NAME A TRUSTEE ON HIS/HER BEHALF** (turn over this form).
		%	
		%	

Employee's signature	**Witness signature**	**Date (mm-dd-yyyy)**

This Section reserved for Plan Office

As Plan Administrator on behalf of the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan, this confirms that the above Change of Beneficiary has been received and registered in the Plan's records.

Plan Administrator's Signature	Date (mm-dd-yyyy)

0572.003 52-20-412 02/14 CUPE 1816

BACK

USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN **BENEFICIARY DESIGNATION**

TRUSTEE APPOINTMENT FOR MINOR BENEFICIARY(IES) UNDER AGE 18

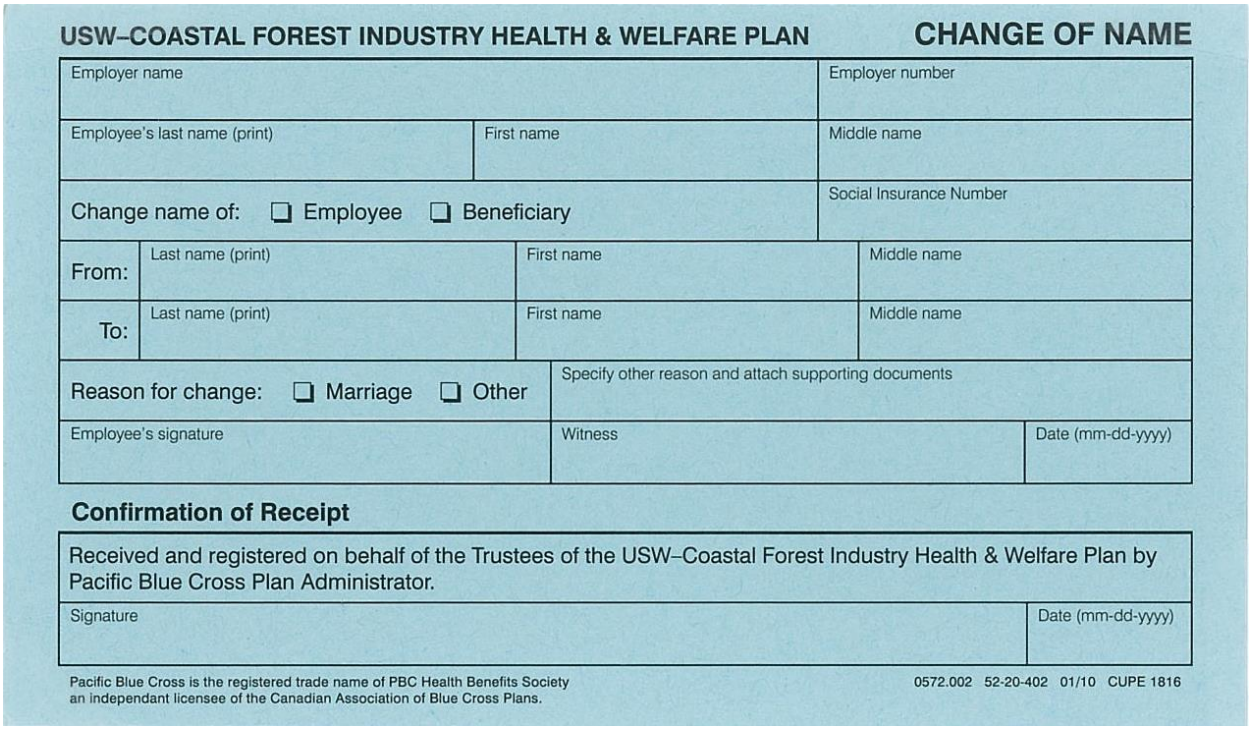
I appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary who is a minor at the time of payment, money payable to the beneficiary under this Plan.
(**If minor beneficiary lives in Quebec:** this form may not be valid; please seek legal advice on how to designate a trustee for a minor beneficiary in Quebec).

Full Legal Name of Trustee	**Relationship to member**
Trustee email address	**Trustee phone number**

Other Trustee notes/contact information

Employee's signature	**Witness signature**	**Date (mm-dd-yyyy)**

4. Change of Name Card



USW–COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN **CHANGE OF NAME**

Employer name			Employer number
Employee's last name (print)	First name		Middle name
Change name of: ❑ Employee ❑ Beneficiary			Social Insurance Number
From: Last name (print)	First name		Middle name
To: Last name (print)	First name		Middle name
Reason for change: ❑ Marriage ❑ Other	Specify other reason and attach supporting documents		
Employee's signature	Witness		Date (mm-dd-yyyy)

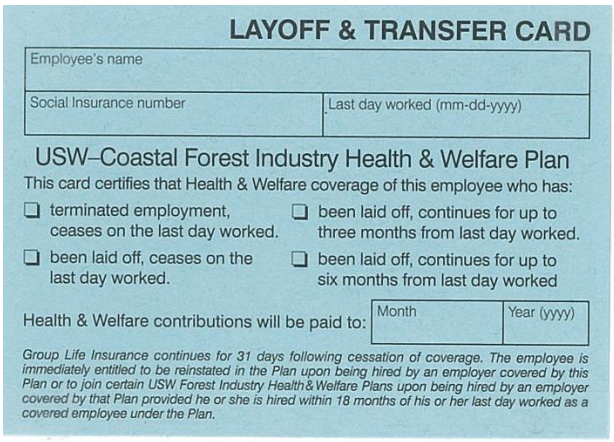
Confirmation of Receipt

Received and registered on behalf of the Trustees of the USW–Coastal Forest Industry Health & Welfare Plan by Pacific Blue Cross Plan Administrator.	
Signature	Date (mm-dd-yyyy)

Pacific Blue Cross is the registered trade name of PBC Health Benefits Society an independant licensee of the Canadian Association of Blue Cross Plans.

0572.002 52-20-402 01/10 CUPE 1816

Transfer Card



LAYOFF & TRANSFER CARD

Employee's name	
Social Insurance number	Last day worked (mm-dd-yyyy)

USW–Coastal Forest Industry Health & Welfare Plan

This card certifies that Health & Welfare coverage of this employee who has:

❑ terminated employment, ceases on the last day worked.

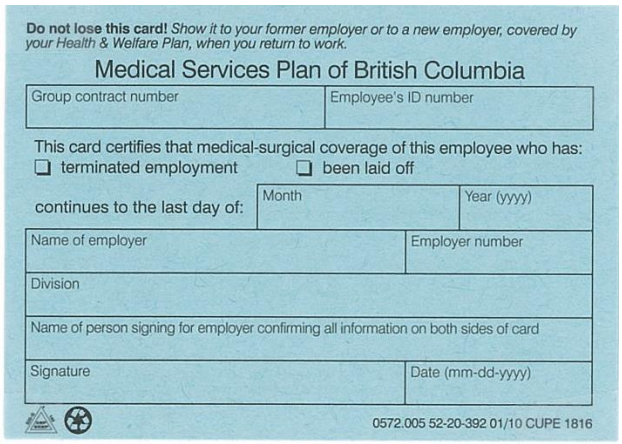
❑ been laid off, ceases on the last day worked.

❑ been laid off, continues for up to three months from last day worked.

❑ been laid off, continues for up to six months from last day worked

Health & Welfare contributions will be paid to: Month | Year (yyyy)

Group Life Insurance continues for 31 days following cessation of coverage. The employee is immediately entitled to be reinstated in the Plan upon being hired by an employer covered by this Plan or to join certain USW Forest Industry Health & Welfare Plans upon being hired by an employer covered by that Plan provided he or she is hired within 18 months of his or her last day worked as a covered employee under the Plan.



Do not lose this card! *Show it to your former employer or to a new employer, covered by your Health & Welfare Plan, when you return to work.*

Medical Services Plan of British Columbia

Group contract number	Employee's ID number

This card certifies that medical-surgical coverage of this employee who has:
❑ terminated employment ❑ been laid off

continues to the last day of: Month | Year (yyyy)

Name of employer	Employer number
Division	
Name of person signing for employer confirming all information on both sides of card	
Signature	Date (mm-dd-yyyy)

0572.005 52-20-392 01/10 CUPE 1816

5. Union Notification of Claim Form

USW-COASTAL FOREST INDUSTRY HEALTH AND WELFARE PLAN (*)

UNION NOTIFICATION OF CLAIM

TO: _____

NAME OF EMPLOYEE: _____

SOCIAL INSURANCE NUMBER: _____

This is to advise you that the above employee, whose

ADDRESS IS: _____

_____

has applied, OR, application has been filed for:

Weekly Income Benefits - LAST DAY WORKED: _____

Accidental Dismemberment - DATE OF DISMEMBERMENT: _____

* Group Life Insurance - DATE OF DEATH: _____

* Accidental Death Insurance - DATE OF DEATH: _____

*NAME OF BENEFICIARY: _____

ADDRESS: _____

_____

Has a Claim been filed with the Worker's Compensation Board?

YES_____ NO _____

The Claim was Forwarded to: USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN
c/o PACIFIC BLUE CROSS*,
P.O. BOX 24715, STN F, VANCOUVER, B.C. V5N 5T8

on _____
(Date)

This information is supplied to you in accordance with the terms of the USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

FIRM NAME OF EMPLOYER: _____

DIVISION: _____

DATE: ._____ SIGNED FOR THE EMPLOYER BY:_____

DISTRIBUTION:
- Original to Local Union Office.
- Copy to Pacific Blue Cross* (attached to claim form)

* Pacific Blue Cross is the registered trade name of PBC Health Benefits Society
(*) formed by the merger of USW Forest Industry Health & Welfare Plans Nos. 1 and 2 [bh:iw1func]
CUPE 1816

6. BC Life Short Term Disability Claim Form

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

CLAIM FOR SHORT TERM DISABILTY BENEFITS USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

Mail: PO Box 24715 Stn F, Vancouver, BC V5N 5T8 | Drop it off: 4250 Canada Way, Burnaby, BC | Phone: 604 419-2000 Toll-free: 1 877 722-2583 Fax: 604 419-8099

Notice of claim must be given no later than 20 days following the first day of illness or accident, and proof submitted withing 90 days. Short Term Disability Benefits are self-insured by the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan. Have the attending physician complete the back of this form and then return it to your employer.

PART 1 — EMPLOYEE'S STATEMENT

Name | Address | City/province/postal code

Job classification or title | ☐ Permanent address ☐ Mailing address | Daytime phone number (ten digits)

Local union number | Date of accident or start of sickness | 1. Physician's name and address

Date last worked (mm-dd-yyyy) | Date of first treatment (mm-dd-yyyy) | 2. Physician's name and address

Is claim being made for WorkSafeBC? ☐ Yes ☐ No | 3. Physician's name and address

Nature of sickness or injury | Date you returned to work (mm-dd-yyyy) | If you have not returned to work, what is expected return date?

If injured, where did accident happen? | School grade reached | Previous job held

Describe accident | Give a brief summary of your education and work experience (attach sheet if more space is needed)

Are you in receipt of benefits from the IWA Forest Industry Pension Plan? ☐ Yes $_____ per month ☐ No

PART 2 — EMPLOYEE'S CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your claim.

I certify that the above statements are correct and hereby authorize my physician and hospital to give BC Life, FIDAS - Forest Industry Disability Adjudication Services, the Trustees of the USW-Coastal Industry Health & Welfare Plan and the Trustees of the IWA Forest Industry LTD Plan any additional information required in connection with this claim. I understand that my benefits will be reduced by Federal Income Tax.

Employee's signature X | Date (mm-dd-yyyy)

PART 3 — EMPLOYER'S STATEMENT

Group number 008942 | Name of Employer | Division | Sub Division | Phone #

Employee's name | Identification number/Social Insurance Number | Job classification | Date of birth (mm-dd-yyyy) | ☐ Male ☐ Female

Brief description of job duties (attach sheet if more space is needed)

For stat holiday purposes does employee work as a logger? ☐ Yes ☐ No

Date employee last worked (mm-dd-yyyy)

Has employee returned to work? ☐ Yes ☐ No

If yes, date of return (mm-dd-yyyy)

Is this claim one which might come under WorkSafe BC or Occupational Disease Regulation? ☐ Yes ☐ No

If Yes, attach copies of relevant WorkSafeBC correspondence.

Have you any reason to question the validity of this claim? ☐ Yes ☐ No

If Yes, state reason(s)

At the start of disability, the employee was:

☐ Working full time (with regular days off)

Circle days off if employee works alternative shifts: Sun Mon Tue Wed Thu Fri Sat

☐ Laid off work | Date layoff commenced (mm-dd-yyyy) | Number of months coverage entitlement due to seniority

☐ On leave of absence | From (mm-dd-yyyy) | To (mm-dd-yyyy)

Reason

Is leave for extended vacation or apprenticeship training? ☐ Yes ☐ No

☐ On vacation with pay | From (mm-dd-yyyy) | To (mm-dd-yyyy)

PART 4 — EMPLOYEE'S CONSENT AND DECLARATION

I certify that the above statements are correct.

Employer's signature X | Employer's name (please print) | Email | Date (mm-dd-yyyy)

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BC Life Short Term Disability Claim Form

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

CLAIM FOR SHORT TERM DISABILTY BENEFITS USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

Mail: PO Box 24715 Stn F, Vancouver, BC V5N 5T8 | Drop it off: 4250 Canada Way, Burnaby, BC | Phone: 604 419-2000 Toll-free: 1 877 722-2583 Fax: 604 419-8099

Notice of claim must be given no later than 20 days following the first day of illness or accident, and proof submitted within 90 days. Short Term Disability benefits are self-insured by the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan. Accurate assessment of this claim depends on each question being answered in full. The patient is responsible for any charges made for completion of this form.

PART 1 — PHYSICIAN'S STATEMENT

Patient's name | Age

Primary diagnosis

Secondary diagnosis (if applicable)

How does the present condition affect the patient's ability to work (e.g. restrictions, limitations, proposed surgery)

Nature of treatment (e.g. medication prescribed, type of treatment, frequency)

Were diagnostic studies made? ☐ Yes ☐ No | Date(s) of studies (mm-dd-yyyy) | Type of studies and findings

If patient was referred to you, name of referring physician | If you have referred patient to a specialist, name of physician and specialty

Date you first treated the patient for this condition (mm-dd-yyyy) | Date of last treatment (mm-dd-yyyy) | If disability related to pregnancy, expected delivery date (mm-dd-yyyy)

If hospitalized, name of hospital | Date admitted to hospital (mm-dd-yyyy) | To (mm-dd-yyyy)

What surgery, if any, was performed | Date of surgery (mm-dd-yyyy)

If disability is due to an accident, date accident occurred | If claim was reported to WorkSafeBC, or in any way related to the patient's occupation, give details

If patient is receiving a pension, give details of pensionable disability

Check dates of visits, exclusive of above procedures.

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Office																																
Hospital																																
Home																																

To the best of your knowledge, indicate the period that the patient has been unable to work at his or her own occupation as a result of the condition | From (mm-dd-yyyy) | To (mm-dd-yyyy)

Approximately when should patient be able to return to work? | Date (mm-dd-yyyy) | Or number of weeks

Prognosis

Remarks (Provide any details which you feel would be helpful)

PART 2 — PHYSICIAN'S AUTHORIZATION

I certify that the above statements are correct.

Physician's name (please print) | Specialty | MSC number | Phone number (10 digits)

Address | City | Province | Postal code

Physician's signature
X | Date (mm-dd-yyyy)

PART 3 — PATIENT'S AUTHORIZATION

I hereby authorize the release to BC Life, FIDAS - Forest Industry Disability Adjudication Services, the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan and the Trustees of IWA Forest Industry LTD Plan, any additional information requested with respect to this claim.

Patient's signature
X | Date (mm-dd-yyyy)

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7. Return to Work Notice

British Columbia Life & Casualty Company

USW-COASTAL FOREST INDUSTRY HEALTH AND WELFARE PLAN RETURN TO WORK NOTICE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-8099 | pac.bluecross.ca

Please complete this form the day the employee returns to work after claiming Disability Benefits.
Mail or fax completed form immediately to British Columbia Life & Casualty Company at the above address.

PART 1 — TYPE OF CLAIM

☐ Short-term disability ☐ Long-term disability ☐ Waiver of premium

PART 2 — EMPLOYEE'S INFORMATION

Employee's name	Group number	Identity number

Date returned to work (mm-dd-yyyy)	Employer's name

Remarks:

PART 3 — AUTHORIZED SIGNATURE

Authorized official's signature	Date (mm-dd-yyyy)
X	

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8. Notice of Leave of Absence

USW-Coastal Forest Industry Health & Welfare Plan
c/o PO Box 24715, Stn F, Vancouver, BC V5N 5T8

Notice of Leave of Absence

Email: admn@pac.bluecross.ca

Please complete this form the day the employee has been approved for Leave of Absence.
Email or fax completed form to the above address.

PART 1 - EMPLOYEE'S INFORMATION

Employee's Name	SIN

Employer's Name	Division Name (if applicable)	Employer Account Code

PART 2 - APPROVED LEAVE OF ABSENCE INFORMATION

Reason for requested Leave

Start date	Expected return to work date

PART 3 - AUTHORIZED SIGNATURE

Authorized official's signature	Date (mm-dd-yyyy)
X	

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9. WCB Reimbursement Agreement form

USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

REIMBURSEMENT AGREEMENT

EMPLOYER STATEMENT

British Columbia Life & Casualty Company (BC Life) is hereby requested to pay Weekly Indemnity benefits under the terms of the USW-Coastal Forest Industry Health & Welfare Plan to:

Employee name: _____ Certificate number: _____ on account of a period of disability which the employee contends commenced on _____, 20 ____, on condition that the employee agrees to reimburse BC Life to the extent that any Workers' Compensation Board of BC (WCB) benefits received duplicate such Weekly Indemnity payments or are received with respect to the same period of disability, as specified in the Plan text.

We certify that a full and proper claim was filed with WCB with respect to the above-mentioned disability at least four weeks ago on behalf of the above-mentioned employee, and that no decision has been reached concerning the member's claim, or the claim has been disallowed and an appeal of that decision has been filed (an appeal is not necessary if the employee's physician confirms that the cause and nature of the disability is non-occupational).

We undertake to inform BC Life, in writing, of the WCB decision in this matter as soon as such a decision is made known to us.

Employer name: _____ Signature of Official Representative: _____

Division: _____ Title: _____

WCB claim number: _____ Dated: _____

EMPLOYEE STATEMENT

With respect to my period of total disability which commenced on _____, 20 ____, I declare that I have made a full and proper claim to WCB and that such claim requires further consideration by the Board with respect to that claim, or my WCB claim has been disallowed and, if appropriate under the terms of the Plan text, I have filed an appeal of that decision.

Pending payment in respect of my claim, I request that BC Life pay Weekly Indemnity benefits to me for the above-mentioned period of disability in accordance with the terms of the Plan text.

In consideration for the above, I hereby agree and undertake that, should such claim result in any payment being made to me by WCB for the same period of disability, I will refund BC Life the full amount (or less if the WCB payment is a lower amount) paid to me under this Agreement immediately upon receipt of such payment. In this regard, in accordance with WCB Policy 48.20, I authorize WCB to mail cheques payable to me for the disability period that commenced on the above date, in care of BC Life, PO Box 7000, Vancouver, BC, V6B 4E1.

Pursuant to the provisions of the applicable provincial and federal privacy legislation, I authorize WCB to release to BC Life the status of my claim and all details of the settlement, including the amount of money awarded to me for my claim, and the date(s) such money was awarded. I agree that BC Life may also release to WCB information directly related to the settlement of my claim and calculation of amounts repayable to the Plan. BC Life will use this information solely for calculating the balances repayable for my claim.

I have read, understood and agree to the above.

Signature of employee: _____ Signature of witness: _____

Dated: _____ Dated: _____

Address: _____ Witness name/address: _____

Please send **the original** of this form to BC Life, with a copy to WCB. The Employer and Disabled Employee should also retain copies.

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10. Life Insurance Conversion Options letter

Trustees of the
USW- Coastal Forest Industry Health & Welfare Plan[1]
c/o Pacific Blue Cross[2]
PO Box 24715, Stn. F, Vancouver, BC V5N 5T8
☎: 604 419-2476 FAX: 604 419-2884 Email: admn@pac.bluecross.ca Web: http://uswfi1.planoffice.ca/

_____

_____
_____
_____

Dear Mr. _____:

RE: USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN
LIFE INSURANCE CONVERSION OPTIONS
POLICY #

The Group Life Insurance benefit is kept in force for you until the age 65 provided you have been totally disabled in accordance with the terms of the master contract.

Since you are reaching the age of 65, your Group Life Insurance will be terminated as of _____.

You have the option of converting your group life insurance to a personal life insurance plan. We have enclosed some information on this conversion option. Please be advised that you have only 31 days from the date of termination of your group life insurance coverage to contact BC Life & Casualty if you wish to convert to a personal plan.

For information on converting your group life insurance to an individual policy, please contact BC Life directly at 604-419-8040 and give them the information on the attached "Conversion from Group Term Life" form.

Group Life Conversion can be a very valuable option, especially for someone not in good health. But if you are in good health, especially if you are a non-smoker, you may wish to talk with your insurance broker to find out if you would qualify for a lower rate based on medical evidence.

Yours truly,

Elaine Howell
Administrator: Life, AD&D and Waiver Claims
☎ 604 419-2423
☎ 1-855 419-2423 (toll free)
✉ ehowell@pac.bluecross.ca

EH:bh:chwfltde
CUPE 1816

(1) formed by the merger of the USW-Forest Industry Health & Welfare Plan No. 1 and USW-Forest Industry Health & Welfare Plan No. 2
(2) Pacific Blue Cross™, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

11. BC Life – Conversion from Group Term Life form

British Columbia Life & Casualty Company

Conversion from Group Term Life

Ensure that all the information required is provided prior to forwarding this form to BC Life.

British Columbia Life & Casualty Company
PO Box 7000 Vancouver BC V6B 4E1
604 419-8040 Toll-free 1 888 275-4672
Fax 604 419-8055
conversion@pac.bluecross.ca
www.pac.bluecross.ca

If your Group term life Insurance terminates on or before your 65th birthday, you may convert without evidence of insurability, all or part of this Group term life Insurance to an individual policy offered and underwritten by Blue Cross Life Insurance Company of Canada. This option does not apply to schedule reductions or termination of coverage which becomes effective at a specified age. The amount of insurance converted will not be less than the minimum amount for which Blue Cross Life Insurance Company of Canada issues an individual policy.

The maximum amount, which may be converted, will be limited to the lesser of $200,000.00 or the amount of terminated life insurance under this Policy less any amount for which you may become eligible under any other group policy within 31 days after your insurance terminates.

The individual policy will be issued subject to receipt of the first premium and a duly completed application within 31 days of the date of termination of your group life insurance. The type of individual policy applied for will be without disability, accidental death or critical illness benefits and may be an individual policy of term insurance for a period of 1 year or a term period to age 65.

If you would like a quotation, please submit the following information to our office.

Name		Identification number
Address		Postal code
Phone	Email address	
Policy number and name		Date of birth (mm/dd/yyyy)
Amount of coverage currently in place	Termination date (mm/dd/yy)	Last date of active work (mm/dd/yyyy)
Reason for leaving the company		
Today's date (mm/dd/yy)	Signature	

*BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross.

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12. BC Life – Life Insurance & Accidental Death Claim form

British Columbia Life & Casualty Company

Employee Life Insurance & Accidental Death **Claim Checklist**

Before mailing your claim, check that:
- All information has been provided. Failure to provide all information may delay your claim.
- Forms have been dated and signed
- All required forms are submitted (see details below)

You must submit this claim to BC Life by the policy claiming deadline.

Disability & Life Claims Department
PO Box 7000 Vancouver BC V6B 4E1

Telephone 604 419-8040
Toll-free 1 888-275 4672
Fax 604 419-8055

Help us to process your claim quickly and accurately. Ensure that the following forms are completed and that the originals of these forms are submitted. Submit the Employee Life Insurance & Accidental Death Claim form (which includes the Employer's Statement and the Claimant's Statement) as soon as they are completed. Do not delay submitting your claim while waiting for the Attending Physician's Statement of Death or Coroner's report.

Your claim will be processed when all three of the following documents are received:

- ☐ Employee Life Insurance & Accidental Death Claim form
- ☐ Attending Physician's Statement of Death
- ☐ Government-issued Certificate of Death

At least one of either the Attending Physician Statement or the Certificate of Death must be an original. Original documents will be returned on request.

Self-administered and third-party administrators should also forward a copy of the group enrollment form.

Your claim for this benefit must be submitted to BC Life by your policy claiming deadline. If you have any questions about your claim or about these forms, contact our BC Life Claims department at 604 419-8040.

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1

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British Columbia Life & Casualty Company

Employee Life Insurance & Accidental Death
Claim Form

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Employer's Statement

Name of group policyholder _____ Policy number _____

Division _____ Class _____ Sub-division (if applicable) _____

Name of deceased _____ Identification number _____

Address of deceased _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____

Date of birth _____ mm/dd/yy Date of death _____ mm/dd/yy

Date employed _____ mm/dd/yy Job title _____ Date last worked _____ mm/dd/yy

Reason the employee stopped working (retirement, illness, leave of absence, termination etc.) _____

Effective date of deceased's insurance _____ mm/dd/yy Date premiums paid to _____ mm/dd/yy

Basic earnings on last day worked: $ _____ per _____ Amount of insurance in force at death: $ _____

Beneficiary _____ Relationship to deceased _____

Beneficiary _____ Relationship to deceased _____

Beneficiary _____ Relationship to deceased _____

NOTE: If a beneficiary has been designated, provide the required information above. If beneficiary predeceased the insured person, benefits under the terms of the group policy will be paid to the insured person's estate. Attach any requests for change of beneficiary which have not been submitted to the insurer.

Complete only if applying for the Accidental Death benefit

Date of accident _____ mm/dd/yy Did the accident occur while the deceased was engaged in company business ☐ Yes ☐ No

If yes, provide details _____

Effective date of deceased's AD&D insurance _____ mm/dd/yy Date AD&D premiums paid to _____ mm/dd/yy

Is this a self-administered plan? ☐ Yes ☐ No If yes, attach the original application form and any change cards.

Is this a third party administered plan? ☐ Yes ☐ No If yes, attach a copy of the billing for the month of death, the original application card and any change cards.

Please provide any other information that will help BC Life assess this claim _____

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Completed by (print) _____ Phone number _____ Date _____ mm/dd/yy

Signature of authorized official _____ Title _____

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Employee Life Insurance & Accidental Death Claim Form

Please ensure this form is fully completed before submitting it to BC Life & Casualty Company.
Failure to provide all information requested could delay assessment.

Claimant's Statement

Name of deceased _____

Policy number _____ Identification number _____

In what capacity are you claiming the insurance proceeds? ☐ beneficiary ☐ executor ☐ administrator
☐ trustee for a minor child ☐ other (specify) _____

Name of claimant _____

Social insurance number _____ Date of birth _____ mm/dd/yy

Address of claimant _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____

Relationship to deceased ☐ spouse ☐ brother ☐ sister ☐ child ☐ Other (specify) _____

Complete only if applying for the Accidental Death benefit

Date of accident _____ mm/dd/yy Time of accident _____ ☐ A.M. ☐ P.M.

Where did the accident happen? _____

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to British Columbia Life & Casualty Company (BC Life), all information in their possession or within their knowledge in respect to the deceased. I agree that a photocopy of this authorization shall be as valid as the original. I certify that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of claimant _____ Date _____ mm/dd/yy

Additional Beneficiaries

If more than one beneficiary is entitled to receive the insurance proceeds, only the claimant indicated above is required to sign the authorization, but the others must apply for the insurance proceeds by providing the infomation requested below:

Name _____ Date of birth _____ mm/dd/yy

Address _____

Relationship to deceased _____ Social insurance number _____

Name _____ Date of birth _____ mm/dd/yy

Address _____

Relationship to deceased _____ Social insurance number _____

* BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross. 0544.002—92-60-128 06/12 CLIFE 1816 Page 2 of 2

BC Life® British Columbia Life & Casualty Company

Attending Physician's Statement of Death

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

May be completed by coroner

Name of deceased _____

Date of birth Mo Day Yr Date of death Mo Day Yr Age at death _____

Place of death (if hospital or institution, give name) _____

Cause of death: Principal cause _____ Date of onset Mo Day Yr

Contributory causes _____ Date of onset Mo Day Yr

Death was due to: ❑ accident ❑ suicide ❑ homicide Please provide full explanation: _____

If due to an accident, was the accident work related? ❑ Yes ❑ No

Was an inquest held? ❑ Yes ❑ No

Was an autopsy performed? ❑ Yes ❑ No

Please provide findings of inquest or autopsy: _____

I attended deceased from Mo Day Yr to Mo Day Yr

If applicable, was the deceased unable to work due to a medical condition prior to death? ❑ Yes ❑ No

If yes, please provide date of total impairment Mo Day Yr and details of condition: _____

Did you treat or advise the deceased during the three years prior to this last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, receive treatment during the last three years from any other physician or in any hospital or institution? ❑ Yes ❑ No

If yes, to either of the two preceding questions, please provide the following:

Name	Address	Nature of illness or injury	Approximate dates

These statements are true and complete to the best of my knowledge and belief.

Name and specialty (please print) _____

Address (please print) _____ Phone number _____

Signature _____ MD Date Mo Day Yr

The claimant is responsible for the cost of completing this form.

® BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross. 92-60-109 05/04 CUPE1816

13. BC Life – Living Benefit Claim Form

British Columbia Life & Casualty Company

Living Benefit
Employer and Employee Claim Form

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Employer's Statement

Name of group policyholder _____ Policy number _____

Division _____ Class _____ Sub-division (if applicable) _____

Name of employee _____ Identification number _____

Date employed ___ ___ ___ (mm dd yy) Job title _____

Date last worked ___ ___ ___ (mm dd yy) Why did your employee stop working? _____

Regular number of hours worked per week _____ Salary paid up to and including ___ ___ ___ (mm dd yy)

Monthly basic earnings on last day worked $ _____

Has the employment been terminated? ☐ Yes ☐ No If yes, provide date terminated ___ ___ ___ (mm dd yy) and reason _____

_____

Effective date of employee's Life insurance ___ ___ ___ (mm dd yy) Date insurance terminated (if applicable) ___ ___ ___ (mm dd yy)

Amount of life insurance coverage $ _____

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Completed by (please print) _____ Phone number _____ Date ___ ___ ___ (mm dd yy)

Signature of authorized official _____ Title _____

Employee's Statement

Name _____ Date of birth ___ ___ ___ (mm dd yy)

Address _____ Box no. (if applicable) _____

City _____ Province _____ Postal Code _____ Phone number _____

☐ Male ☐ Female Date last worked ___ ___ ___ (mm dd yy)

Please have the Attending Physician's Statement completed.

I, the undersigned, hereby make claim for a Living Benefit. I authorize all physicians and other persons who have attended me and all hospitals, institutions and government authorities to furnish to British Columbia Life & Casualty Company (BC Life), all information in their possession or within their knowledge in respect to myself. I agree that a photocopy of this authorization shall be as valid as the original. I certify that the information provided above is true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

I acknowledge that interest will be charged on the amount of Living Benefit issued by BC Life, and that this interest will be Prime (or the prime lending rate) plus 2%.

Signature of employee or legal representative _____ Date ___ ___ ___ (mm dd yy)

If legal representative, provide copy of Power of Attorney

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British Columbia Life & Casualty Company

Living Benefit Attending Physician's Statement

Please assist your patient by providing all details relevant to his/her condition.

Disability & Life Claims Department
PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Toll-free 1 888-275 4672
Fax 604 419-8055

Patient's surname	Patient's first name	Date of birth (mm/dd/yyyy)

Your above named patient has requested an advance partial payment of his/her Life Insurance benefits due to a terminal illness. To consider this request we require the following information:

Diagnosis

Prognosis

Life Expectancy

Please provide a description of your patient's medical condition, including any complications and treatment in the space provided below. Attach a copy of any recent test results.

Do you believe your patient is competent to endorse cheques and direct use of the proceeds? ☐ Yes ☐ No

These statements are true and correct to the best of my knowledge and belief.

Name of physician (print)	Specialty
Address	Telephone (ten digits)
Signature	Date (mm/dd/yyyy)

The claimant is responsible for the cost of completing this form

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