BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENT

MEMBER INFORMATION			
LOCAL UNION		POLICY # 6128	
LAST NAME	FIRST NAME	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			CERTIFICATE / SIN
CITY	PROVINCE	POSTAL CODE	PHONE

TO: (OOHPHQW&RQVXOWLQJ*URXS on behalf of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan

AND TO: The Member

IN CONSIDERATION of (OOHPHQW&RQVXOWLQJ*URXS (on behalf of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan) agreeing to pay me a weekly disability benefit, I agree that if I am subsequently found not to be entitled to receive a weekly benefit or to have received an overpayment of the benefit that I will, on demand of (OOHPHQW&RQVXOWLQJ*URXS pay to (OOHPHQW&RQVXOWLQJ*URXS the amount of such overpayment.

I acknowledge that an overpayment to me may result if, for example, I am not eligible under the Rules of the Policy for a weekly disability benefit. Additionally, if I am entitled to benefits under Workers' Compensation or a sickness or regular benefit from Employment Insurance, or SGI Accidental Benefits claim, I would be excluded from receiving weekly disability under this Plan. These examples would exclude payments received from an individual disability policy. I acknowledge that the foregoing are examples of why I may not be entitled to receive a full weekly disability benefit from (OOHPHQW&RQVXOWLQJ*URXS and that there may be other reasons why I am not entitled to receive from Ellement Consulting Group that full benefit.

Accordingly, I agree to repay the amount of such overpayment upon demand by Ellement Consulting Group.

DATED at the City of_____, in the Province of _____,

this _____ day of _____, 20____.

SIGNED IN THE PRESENCE OF:

_____ _____

Signature of Witness Signature of Member

_____ _____

Name Name

Address & Phone Number

_____

_____

BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

CONSENT TO RELEASE

MEMBER INFORMATION

LOCAL UNION		**POLICY # 6128**	
LAST NAME	**FIRST NAME**	**GENDER** ☐ Male ☐ Female	**DATE OF BIRTH** (MM/DD/YY)
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I hereby expressly consent, authorize and direct:

- Workers' Compensation Board
- Employment Insurance
- Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan
- Medical Practitioners I have attended
- A center for treatment of addictions that I have attended or will attend

- to disclose any knowledge and information requested by the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan, in respect to my Weekly Disability Benefit Claim.

DECLARATION AND AUTHORIZATION

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize Ellement Consulting Group (ECG), Manulife, Homewood Health Inc. and the Trust Fund ("the Fund") to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, ECG, Manulife Homewood Health Inc. and the Fund will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This information may be used for the following purposes, where ECG, Manulife, Homewood Health Inc. and the Fund deems it necessary: the evaluation and management of this or any other claim for benefits or applications for insurance that I may have with ECG, Manulife, Homewood Health Inc. or the Fund, including claims in litigation, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize ECG, Manulife, Homewood Health Inc. or the Fund and the following persons, institutions, and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control: any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment, any provincial health insurance plan, insurance company, reinsurer, or other financial institution, any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, any investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information.

I hereby authorize the use of my Social Insurance Number for tax income reporting purposes.

I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, including litigation, or services for this claim are required for ECG, Manulife, Homewood Health Inc. or the Trust Fund. A copy of this authorization shall be valid as the original.

(MM/DD/YY)

SIGNATURE OF MEMBER DATE

Ellement
Pensions | Benefits | Investments
Phone (780) 452-5161

Please return original form to:
Ellement Consulting Group
10154 – 108 Street, NW, Edmonton, AB T5J 1L3
Toll free: 1 (800) 770-2998

Fax (780) 452-5388