Participating Employer

ADMINISTRATION MANUAL

FOR THE
SOUTHERN INTERIOR HEALTH & WELFARE PLAN

Updated: October 2026

SOUTHERN INTERIOR HEALTH & WELFARE PLAN ADMINISTRATION MANUAL

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OVERVIEW

This ADMINISTRATION MANUAL has been prepared to provide procedures to provide Participating Employers with the information required to administer the plan in accordance with the Plan rules and procedures.

The Plan is operated by a board of Trustees including three Employer Trustees and three Union Trustees and administered by a Third Party Administrator. Benefits are provided by Pacific Blue Cross and Canada Life. The role of the Plan Administrator is outlined below.

Plan Administration Office

The Trustees have retained AGA Benefit Solutions to administer the Plan. The Plan Administrator performs the following functions:

- Process employee enrolment, change and terminations
- Process employee changes on Pacific Blue Cross
- Receives and processes monthly employer remittance forms
- Manage the Trust's bank account including reconciliation of payment information and payment of invoices
- Assist Participating Employers with any questions regarding the Benefit Plan
- Provide confirmation of coverage to Pacific Blue Cross in the event of weekly indemnity claims
- Manage the life waiver benefits for employees who become disabled during the entire life waiver period

For companies which initiate documents at a single payroll or personnel office, these documents should be sent directly to the Plan office:

Southern Interior Health & Welfare Plan
c/o AGA Benefit Solutions
301E 675 Cochrane Dr
Markham, ON L3R 0B8
Email: sihwp@aga.ca
Phone: 1-800-218-7018
Fax: 905-477-2249

Head Office

For participating employers with more than one location for which consolidations are required, the remittance documents should be sent to the designated office within your organization. Consolidated reports prepared at that office are forwarded to the Plan Administration office.

NOTE: In matters regarding claims, the operating division should deal directly with the Plan Administration Office.

NOTE on Divisions: Circa 1990, there was a project to align divisions and seniority lists, at the direction of the Trustees. That is,

One bargaining unit seniority list = One division.

The intention was to be able to identify when a permanent closure occurred, so that we'd know when to trigger any possible contingent liability calculations. In 2007, an employer requested combining four of their groups into one. The Trustees agreed that the present system is administratively less efficient than allowing seniority lists to be combined for coverage purposes; and the Plan has been managed for a number of years expressly to prevent an overall deficit from occurring. However, the Trustees are concerned that they not take action now which might jeopardize the Plan's position at some future point.

Further Information

Contact AGA Benefit Solutions by email at sihwp@aga.ca or call 1-800-218-7018 and ask for the Plan Administrator responsible for Southern Interior benefit plan if you have general questions about:

- the terms of the Plan,
- enrolments or forms,
- billing questions
- life insurance or AD&D benefits

If you have questions about Dental and Health benefits, contact the Pacific Blue Cross (PBC) Dental Call Centre at 604 4192300 or the PBC Health Call Centre at 604 419-2600. You may also call the toll free number 1-888-275-4672. Claims problems which cannot be resolved at the clerical level may be referred to the more senior level.

For Weekly Indemnity questions, please call Pacific Blue Cross at 604 419-8080.

If you have trouble getting the information or action you need about any of the above, or if you want to bring something to the attention of the Trustees, contact AGA Benefit Solutions and ask to speak to the Plan Administrator.

I. ELIGIBILITY

An eligible member is any employee within the bargaining unit of a Southern Interior forest products operation who is subject to the bargaining authority of Local Unions 1-405, 1-417 and 1-423 of USW, who is not a Part-Time Employee, and whose employer is a member of Interior Forest Labour Relations Association is an eligible employee, including those working a Compressed Work Schedule and Designated Part-Time

Employees. See the Plan Text for definitions of Part-time, Designated Part-Time and Compressed Work Schedule

Dependents of eligible employees are eligible for health and dental benefits under the Plan subject to the duplicate coverage rule (see Duplicate Coverage section for more information). "Dependents of eligible employees" include:

A) the employee's spouse**,
unless the spouse is an eligible employee and enrolled as a member under the Plan, and,

B) any child, step-child, adopted child or legal ward of the employee who is -
financially dependent on and living with the employee or the spouse*
and - unmarried,
and - either - under the age of 21
or - up to and including age 26 in full time attendance at a school or university
and - is not enrolled as a dependent of another eligible employee who is covered by the plan.
and

C) any unmarried mentally or physically handicapped child of an employee to any age who is
- financially dependent on and living with the employee or the spouse*, and
- is not enrolled as a dependent of another eligible employee who is covered by the Plan.

* If the eligible employee and spouse divorce, coverage for dependent children will continue even though they may reside with the former spouse, as long as they continue to be financially dependent on the eligible employee for support.
** An eligible spouse must be legally married to the employee, cohabiting with the employee in a conjugal relationship for at least 12 months.

Dependents will become eligible for coverage on the date they become effective regardless of the date they are added to the plan. If the dependent was eligible the date a member joined the plan coverage will be backdated to that date, otherwise they become effective on the date they meet the definition of an eligible dependent.

II. COMMENCEMENT DATE OF COVERAGE

The rules regarding commencement dates by benefit are summarized in the table in Schedule A. Note that some benefits have different effective dates and the start date for some of them is tied to the "Coverage Qualification Period" as defined in the Plan Text.

Under the terms of the Southern Interior Health & Welfare Plan every person who is an eligible employee (as defined above) will be covered by and must enrol in the Plan based on their status as outlined in the sections below.

Returning to the Bargaining Unit (Supervisors or Union Officials)

Benefit coverage will be effective immediately upon return to the bargaining unit in the case of an employee who had been previously transferred by the Company to a supervisory position, (other than temporary supervisors, who remain covered by the Plan while so employed) or immediately upon return to work in the case of an employee who had been on leave of absence whilst appointed or elected to Union Office.

Previously working while covered within 18 months (Transferred-in Employee)

Coverage will be effective on the first day actively at work for an employee who within the 18 month period prior to employment with your company was either:

- actively employed by an Employer and covered under the SIHWP Plan; or
- actively employed and provided benefit coverage by a collective agreement between the United Steelworkers and one of the following organizations:
    - Forest Industrial Relations Limited;
    - Western Forest Products Inc.; or
    - West Fraser Timber Co. Ltd.:

NOTE: If the employee was entitled to lay-off continuation of coverage through their previous employer, and this period of time has not yet expired upon their employment with your Company, he must still be enrolled immediately upon hiring and their previous Southern Interior employer will be notified by the Plan Administration Office.

All Other Employees

Benefit coverage will become effective on different dates based on the benefit type:

Health Benefits - on the first day of the month following the date of hire.

Life Insurance - on the first day following completion of the Coverage Qualification Period, provided they are Actively at Work. Otherwise, on the first day of return to work.

All Other Benefits - On the first day of the month following the date of completion of the Coverage Qualification Period, provided they are Actively at Work. Otherwise, on the first day of return to work.

“Actively at Work” means that an employee is either actively working on the job site and/or worked their last regularly scheduled work day before the Commencement of Coverage and is not prevented by Sickness or Injury from performing their job.

“Working” includes all activities required in the course of employment, for example training and orientation.

“Coverage Qualification Period” means the period commencing on a Member’s date of hire and ending on the date that the Member first completes 30 working days in period of three consecutive calendar months, assessed on a rolling basis.

Summer Students

Summer students are treated the same as other employees in the same situation. New hires should be added for Health benefits on the first of the month following the date of employment.

However, there is a special rule for new employees who are already covered under the Plan through the parent’s coverage. Normally, coverage under the parent ends when they become eligible for Health coverage, as they are working and no longer considered “financially dependent”. However, this would leave them without dental coverage until their Coverage Qualification period ends.

The student who obtains regular bargaining unit employment while an eligible dependent under the terms of the plan will have their dental bridged. That is, claimable expenses incurred after coming off the parent’s coverage and prior to the first of the month following the student’s completion of their or her Coverage Qualification Period will be paid by this plan.

Therefor upon qualification for Health only, they should be taken off their parent's health coverage. Then, upon completion of the Coverage Qualification Period, they should be fully enrolled in their own right, and taken off their parent's Dental coverage.

When they return to school or otherwise cease to be employed, their coverage would end with no lay-off extension (it's a termination of seniority and not a lay-off), and at that time, if eligible as dependents, be added back to Health & Dental as dependents of their parents.

Summary of Dates of Commencement of Coverage – Schedule A

	Type of Employee				
Benefit	Returning to Bargaining Unit from Supervisory or Union Employment (called "Returning')	Covered Within previous 18 months by SIHWP or other recognized Plan ("Transferred-In")	Regular Employee	Designated Part-Time Employee**	Returning from Disability Employee*
Life	Date of Return to Employment	First day Actively at Work	First of month following end of Coverage Qualification period, OR first subsequent day Actively at Work	First date that member is actively at work following the date on which the member is confirmed as a Designated PT EE	Date of return to Employment
AD&D	Date of Return to Employment	First day Actively at Work	First of month following end of Coverage Qualification period, OR first subsequent day Actively at Work	First date that member is actively at work following the date on which the member is confirmed as a Designated PT EE	Date of return to Employment
Weekly Indemnity	Date of return to employment	First day Actively at Work	First of month following end of Coverage Qualification period, OR first subsequent day Actively at Work	First date that member is actively at work following the date on which the member is confirmed as a Designated PT EE	Date of return to Employment
Health	First of month following return to Employment	First day Actively at Work	First of month following date of hire, OR first subsequent Actively at Work	First date that member is actively at work following the date on which the member is confirmed as a Designated PT EE	First day of the month following the date of return to Employment
Dental	First of month following return to Employment	First day Actively at Work	First of month following end of Coverage Qualification period, OR first subsequent day Actively at Work	First date that member is actively at work following the date on which the member is confirmed as a Designated PT EE	First day o f the month following the date of return to Employment
NOTE: Laid off employees returning to work following the expiry of their lay-off coverage but within 18 months of last day at work as a covered employee are covered for all benefits on the first day Actively at Work. For a full discussion of the Plan's lay-off provisions, see Section V of the Administration Manual.					
* Provided coverage was in effect on date of disability, coverage remains in force throughout the WI or WCB Wage Loss period. LTD claimants are provided only with Life insurance coverage under the SIHWP plan. The LTD Plan provides Health and Dental coverage. If employee recovers and returns to employment with seniority remaining, they are covered immediately.					
** Designated Part-Time Employees must have met the coverage qualification period to become eligible for benefits as at the date they are confirmed as a designated part-time employee, otherwise coverage will be become effective on the date they meet the coverage qualification period.					

III. ENROLMENT AND BENEFICIARY DESIGNATION

Overview

Before an eligible employee starts work, have them complete the Enrolment and Change Form which includes the beneficiary designation for life and accidental death benefits.

Completing the Enrolment and Change Form

Section 1 – Employer/Plan Administrator

- Complete the employer and division name and include the division/subdivision number to make sure that employees get enrolled in the correct plan.
- Use the employee's legal name.
- Include the payroll number – AGA can track this number to enable easier reconciliation of your member data against your payroll records.
- Note the date of hire and the health effective date. If you are aware that the employee qualifies as transferred in to start benefits immediately put this in the notes or include any other pertinent information regarding the employee's benefit effective dates. Members are enrolled for the health benefit only based on the initial enrolment form. You can communicate the date the employee satisfies their Coverage Qualification period to age by email at sihwp@aga.ca, or you can include this information with the monthly remittance form.
- Sign and date the form and include contact information so the Plan Administrator can contact you if there are questions.

Sections 2/3/4 – Member & Dependent Information

- Employee is to complete all these sections fully – see "Use of Social Insurance Number" below if employees do not want to complete this information.
- The question regarding any previous coverage under the Southern Interior Health & Welfare Plan or a related plan is extremely important. Have the employee print their previous employer's name and division in the space provided.
- Street and mailing address are requested because PBC will mail claim payments until a member signs up for direct deposit claims payment.
- Email address is requested as AGA uses email as the primary means of communication with member. AGA will only use this information for purposes of administering the benefit plan and most requests for update are sent to the member through the employer payroll/HR contacts.
- All dependents should be added even if they have their own coverage. In the case of duplicate coverage under the SIHWP plan, the dependents should be listed, but the member will be given single health and dental coverage.

Section 5 & 6 – Beneficiary Designation

- Employees should complete this section to name the beneficiary for their group life and ad&d benefits.

- If the beneficiary section is left blank, the benefit would be paid to the employee's estate if they pass away. Claims payable to the estate generally take longer to be paid and will be paid into the estate so cannot be disbursed until the estate is settled and may be subject to taxes. Unless the employee has detailed estate planning it is usually better in most situations for employees to designate a named beneficiary.
- If a beneficiary under the age of majority is named (usually under age 18), the employee may want to name a trustee. If no trustee is named, the proceeds of the life claim will be held in trust for the named beneficiary until they reach the age of majority.

Section 7 – Signature

The form is not valid unless it is dated, signed by the employee in ink. The form does not require a witness signature but it adds another level of protection in the event of claim dispute to have it witnessed.

Use of Social Insurance Number

Employees explicitly authorize the use of their social insurance number for Plan Administration as part of the consent on the Enrolment and Change form, in accordance with federal legislation.

If an employee refuses to give this authorization he should cross out that sentence ("I consent to the use of...") and initial the change. The employee should be informed that SIN must still be provided with any WI claims, because WI is a taxable benefit and that it will be used for the purposes of a life insurance or AD&D claim.

The Plan Administrator will assign a certificate number for the employee based on their PBC identification number. You can use this number on all correspondence about the employee.

Duplicate Coverage

If an employee and spouse are both covered employees in this Plan, they cannot enrol each other as dependents, and only one may enrol each child as a dependent.

If your employee is covered as a dependent by their spouse, notify the spouse's employer to take them off the other Plan, and ensure each child is only covered once.

If a new employee is covered as a dependent in this Plan by a parent (summer student), after their Health coverage starts they may continue as dependent for Dental only until their full benefits start.

Beneficiary Changes

Employees may change their beneficiary at any time, using the Enrolment and Change Form.

- Check off “Change of Information” on the top of the form
- Complete the employer name
- Leave the rest of the employer information blank
- Have the employee complete
  - ✓ their name in Section 2 and at the top of Page 2 where indicated
  - ✓ their new beneficiary information in Section 5 and 6 (if applicable)
  - ✓ sign and date the form and have a witness sign and date the form
- The employee should complete this form if their beneficiary has a name change – for example if the beneficiary changes a name when they get married
- Employees should be encouraged to review their beneficiary designation any time they are enquiring about changing dependent information.

Change of Name

If your employee has a legal name change or gender change that you have processed for purposes of payroll, and you have collected appropriate proof of the name/gender change, AGA only requires that the employer communicate the name and/or gender change to AGA for purposes of updating the benefit records.

However for clarity it is recommended that employees complete a new beneficiary form in their new name to avoid complications in the event of a death claim (see beneficiary changes above for how to update a beneficiary). They can use the Enrolment and Change Form to update this information (see Beneficiary Changes above).

If an employee has a legal name or gender change for one of their dependents, the employee should forward information to AGA with the old dependent name, new name and proof of the change. Any documentation submitted to AGA will be destroyed once it has been verified.

IV. TERMINATION OF COVERAGE

An employee will cease to be covered by the Plan in accordance with the Summary of Dates of Termination of Coverage in Schedule B below.

Employers can notify the Plan Administrator regarding employee terminations by email as they occur or by listing the terminations on the monthly billing remittance worksheet. All terminations should be forwarded with the billing for the month immediately following the month in which employee is terminated.

NOTE: Terminations should be received within 30 days of effective date. If they are reported late to the Plan Administrator your company will be billed for the cost of any claims paid after the termination date.

Benefit Conversion - Life

An employee whose Group Life Insurance coverage is terminated may have the right to convert life insurance and health and dental benefits to an individual policy without medical evidence of insurability. To exercise this right, they must make proper application to the appropriate insurer and pay the appropriate premium within 31 days from the date of termination of their Group coverage.

The 31-day "Conversion Period" starts on the date of the termination of the life insurance benefit for the member based on the termination of coverage provisions.

Those interested should be given the "Group Life Conversion Privilege Notification" (See Life Conversion Form at the end of this section) 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.

Benefit Conversion – Health & Dental

Pacific Blue Cross used to offer an individual Extended Health Care Plan specifically for retiring USW members who were covered under the Southern Interior Health & Welfare Plan.

This was discontinued however PBC does offer health and dental conversion options for any employee whose coverage is terminating under the group benefit plan – see the Health/Dental Conversion Form at the end of this section.

An individual plan is a direct contract between PBC and the individual, and the contract does not involve the Participating Employers, Local Unions, or Trustees in any way, except that to make departing employees aware of the option.

Important points to note:

- "Conversion Plans" will waive most pre-existing condition exclusions so they are more expensive than other Individual Plans. To be eligible for a Conversion Plan, employees must be covered up to the date of termination and must enrol within the time limit specified for the conversion period – generally 30 days for life insurance and 60 days for health/dental conversions. Coverage will be the first of month following the date of termination.
- Benefits differ from those offered under the Southern Interior Health & Welfare Plan. They are fully described in the individual contract and will be provided to the member by the insurer.
- Please make your retiring and terminating employees aware of this option.

Summary of Dates of Termination of Coverage – Schedule B

	EMPLOYEES OTHER THAN DISABLED EMPLOYEES				
	Laid-off With Less Than 4 Months Seniority	Laid-off With 4 or More Months Seniority	Terminated, Retired or Deceased	On Approved Leave of Absence**	Disabled Employees
Life	Date of lay-off (Conversion period provision may apply*)	Less than 1 year – 3 months from date of lay-off More than 1 year – 6 months from date of lay-off	Date of termination or retirement, or date of death (Conversion period may apply*)	Date LOA ends (Conversion period may apply*)	31 days following date Disability ends, or age 65
AD&D	Date of lay-off	Less than 1 year – 3 months from date of lay-off More than 1 year – 6 months from date of lay-off	Date of termination, retirement or death	Date LOA ends	Exact date of cessation of WCB Wage Loss(*) or WI payments
WI	Date of lay-off	1 year – 3 months from date of lay-off More than 1 year – 6 months from date of lay-off	Date of termination(unless disabled), retirement or death	Exact date LOA ends	Date of cessation of WCB Wage Loss(*) or WI payments
Health	Date of lay-off	1 year – 3 months from date of lay-off More than 1 year – 6 months from date of lay-off	End of month in which termination, retirement or death occurs	End of month in which LOA ends	End of month in which WCB Wage Loss(*) or WI payments cease (5)
Dental	Date of lay-off	1 year – 3 months from date of lay-off More than 1 year – 6 months from date of lay-off	End of month in which termination, retirement or death occurs	End of month in which LOA ends	End of month in which WCB Wage Loss(*) or WI payments cease (5)
*There are situations where the life insurance benefit will be treated as covered for a member during the 31 day conversion period following the termination of the benefit.					
**See Plan Text for full description of applicable leaves. All benefit coverage will be extended for the duration of the approved leave of absence however employees who are suspended or otherwise not receiving earnings will not be entitled to WI benefits because there are no lost wages to replace.					

NOTES

1) On the date a benefit is terminated, all employees are terminated for that benefit.

2) "Terminated" employees include those granted leave of absence under Article XI, Section 3(a) of the Master Agreement (appointed or elected to Union office), or transferred to a supervisory position.

3) For Dental and Health, dependents terminate on the date of member termination, or, if earlier, on

- date of dependent's death
- end of month in which he no longer meets the definition of dependent

5) If a Disabled Employee's employment ends while on WCB Wage Loss(*) or WI, then
   - AD&D ends <u>on the day</u> employment ends.
   - Dental and Health end <u>at the end of the month</u> in which employment ends.
   - WI and Life insurance continue as if employment had not ended. If the employee took severance as part of a permanent closure or reduction, then the employer pays a reduced monthly contribution, otherwise no contributions are due. In February, 2009, the Trustees agreed with the Plan office that members whose retirement is facilitated by the Community Development Trust Program are treated the same as other retiring members for this purpose.

6) Coverage while awaiting LTD Adjudication.

- From the minutes of October 3, 1990: "the Plan provide[s] coverage, without employer contributions, for EHB, Dental and Group Life for disabled members whose weekly indemnity or WCB Wage Loss(*)benefits have ended, provided an application has been filed with the IWA Forest Industry LTD Plan, until the LTD Plan has adjudicated it, for up to three months. If adjudication is not complete after three months, [PBC] is to refer to the Trustees for possible extension."
- In the minutes of August 9, 2001, it was noted that a member's LTD claim was denied but he filed an appeal, and asked that benefits be continued a further 3 months. Their coverage was continued until their LTD appeal was exhausted. The Trustees ratified the continuation, and the implication is that similar applications would be considered in the future.
- Also on August 9, 2001, the Trustees confirmed that requests for coverage continuation while awaiting LTD Adjudication (or appeal) should be forwarded to the Claims Appeals Committee.

(*) Wherever the term "WCB Wage Loss" is used in this Administration Manual, it is understood to include WCB Income Continuity or Rehabilitation Allowance.

Group Life Conversion Form

canada life

Group Life Conversion Privilege Notification

Plan Administrator Section: PART 1

Complete the fields below, give one copy of this form to the plan member upon termination or reduction of group life insurance, and keep a copy for your files.

1. Group life insurance policy - advisor information (if applicable)

Advisor	Telephone Number	Fax No.
	( )	( )
Address	**Email Address**	

2. Plan member/spouse information

Plan Member's Name	Gender	Date of Birth (month/day/year)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other	
Spouse's Name (if eligible for spousal conversion)	**Gender**	**Date of Birth (month/day/year)**
	☐ Male ☐ Female ☐ Undisclosed ☐ Other	
Address		**Telephone Number**
		( )

3. Group life insurance information

Group life policy name:					
		Policy no.:	Reduced/terminated amount:	Combined (max $200,000 per person) conversion maximum	Date insurance reduced/terminated (month/day/year)
Plan Member	Basic		$	$	
	Optional		$		
	Supplementary		$		
Spouse	Basic		$	$	
	Optional		$		

4. Plan administrator information

Plan administrator's name (please print)	Telephone number	Email
	( )	
Plan administrator's signature		**Date (month/day/year)**

Plan Member/Spouse Section: PART 2

If your Canada Life group life insurance has been terminated or reduced, you may be able to purchase an individual life insurance conversion policy, without providing medical evidence of insurability. The group life conversion application must be received by Canada Life within 31 days after your group life coverage terminates or reduces. Here's what you need to do to convert your group life insurance:

Step 1: Give this completed Group Life Conversion Privilege Notification form to your advisor.

a) If you do not have an advisor or your advisor is not licensed to sell Canada Life products, please visit https://canadalife.com/contact-us/existing-customer/workplace/life-insurance-convert-personal-product.html.

After you submit the form, an advisor will contact you and explain the group life conversion options available so you can make the right choice based on your insurance needs.

b) You may also speak to a customer service representative by calling: 1-888-252-1847. The customer service representative will assist in connecting you with an advisor.

c) You may also reach us by email: stay_covered@canadalife.com.

Step 2: After you have decided on your group life conversion option, the advisor will submit the completed and signed application, with the first full premium payment to Canada Life for processing. This application process must be completed within 31 days after your group life insurance terminates or is reduced.

M5725-11/24 Clear

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Health/Dental Conversion Form



Note: the form shows Life and Critical Illness but these benefits are not available for members of the SIHWP to convert because they are not covered with Pacific Blue Cross (Life Insurance) or they do not have the benefit (Critical Illness)

V. LAY-OFF

An employee who is laid-off is entitled to and will be granted continuation of coverage for a period of three months provided he has at least four months' seniority or six months provided he has at least one year of seniority.

Employers must notify the Plan Administrator when employees are laid off and provide the end date of the benefit coverage for all employees who have been laid off. For employees who return to work periodically or job-share during a period of lay-off the employer must update the Plan Administrator on a monthly basis regarding the status of the member to confirm their continuing eligibility under the lay-off provisions.

Employees who are laid off but have coverage continued for three or six months should continue to be counted as employees covered for all benefits on the SIHWP Billing Remittance Form.

Lay-off Extension

Lay-off extension is counted from the exact date of lay-off.
See "COVERAGE DURING LAY-OFF - EXAMPLES" on the next page, and "SUMMARY OF DATES OF TERMINATION OF COVERAGE" in this manual.

Return from Lay-Off

The following rules regarding extension of lay-off coverage, and reinstatement of lay-off coverage in cases where one of your laid-off employees returned to work are complicated. For explanations and examples see "COVERAGE DURING LAY-OFF - EXAMPLES" on the next page.

Return to regular employment (no known date of future lay-off)

Full coverage is restored, and full lay-off coverage is reinstated.

Return to work for a temporary period - 10 days worked within a 30 day period.

Working 10 days or more within a 30 day period, within the seniority period, results in a full reinstatement of original lay-off extension (3 or 6 months, depending on seniority), in the event of a subsequent lay-off.

Return to work for a temporary period - less than 10 days within a 30 day period.

If the return to work (for less than 10 days) occurs before the expiry of layoff coverage, it earns coverage for that month, in effect extending existing lay-off coverage by one month.

If the return to work occurs after the expiry of the lay-off coverage (3 or 6 months, depending on seniority), coverage starts immediately on return to work, and continues until the end of the month.

Note: Contributions are to be paid for that month if the return occurs from the 1st to the 15th of the month, inclusive. No contributions are required if the return occurs from the 16th to the 31st, inclusive.

Coverage During Lay-Off - Examples

SCHEDULE C

Member with 2 years seniority is laid off January 7.

- Lay off extension is until July 7.

Member returns to work March 7, 8, 9.

- This “buys” March coverage
- Lay-off extension is now until August 7.

Member does not return to work before August 7

- Coverage terminates August 7 for AD&D, WI.
- Coverage terminates August 31 for Health, Dental
- Coverage terminates September 7 for Life (see section IV)
- Contributions are due through August, even though the member is not covered for August 8 - 31 for some benefits.

Member works September 12, 13, 14

- Coverage starts September 12 for all benefits.
- Coverage terminates September 30 for all benefits.
- Contributions are due for September even though the member is not covered for September 1 - 12.

Member works October 24 - 28

- Coverage starts October 24 for all benefits
- Coverage terminates October 31 for all benefits.
- Contributions are not due for October, since start date is later than 15th.

Member works November 21 - December 9

- By working 10 or more days in 30, the member’s lay-off coverage is reinstated.
- Coverage starts November 21 for all benefits.
- Contributions are not due for November, since start date is later than 15th.
- Lay-off extension is now until June 9 and contributions are due from December 1 through to June 30.

EI Job-Share

Sometimes, in order to maintain crews during downturns with reduced impact on personal income and future EI eligibility, arrangements are made between an employer, the local union, and employees, where two employees essentially share one job. For instance, Employee A might work 3 days in week 1 and claim the other 2 days as EI income benefits; Employee B would work the other 2 days in week 1 and claim the other 3 days as EI income benefits, Then in week 2 the days would be switched, and so on. There are other possibilities.

This is essentially the same as a common situation where an employee without steady employment has an open EI income claim, reports their days of work, and is paid EI for days not worked. Total EI entitlement is stretched out by days worked. From the Plan's point of view,

- The member is laid off – recalled – laid off – recalled - laid off ... and so on.
- Under regular lay-off and recall rules, he continues as a fully covered employee,
  - with lay-off coverage 'stretched' by each month in which a day is worked, and
  - continually reinstated whenever at least 10 days worked in a month.
- If disabled, the member is eligible for full WI benefits just like any other employee. IT IS IMPORTANT for the member to STOP their EI claim, because (a) the WI benefit is based on a full week of disability; and (b) to protect their EI eligibility against future events.

VI. BILLINGS AND REMITTANCE

Coverage of Employees and Required Contributions

Participating Employers of the Southern Interior Health & Welfare Plan self-remit contributions for covered employees. Contributions are paid on a monthly basis:

- for employees whose coverage commences during the month, payment is made if the effective date is from the 1st through the 15th, inclusive.
- if coverage commences from the 16th through 31st, no payment is required.

For employees whose coverage ends during the month:

- payment is made if the date coverage ends is from the 16th through 31st.
- Payment is not required for those employees whose coverage terminates from the 1st through the 15th, inclusive.

Other than the 1 - 15, 16 - 31 rule, no adjustment or pro-rating is made for coverage for part of a month.

New Employees

For new employees, or previous employees who have not worked as a covered employee within the last 18 months (see commencement of coverage for transfer-in qualifications) health coverage starts on the first of the month following the date of

hire, provided employee is “Actively at Work”. Life Insurance takes effect the day after Coverage Qualification Period is completed. The remaining benefits, WI, AD&D, and Dental, take effect on the first of the month following the end of coverage qualification period, again provided employee is “Actively at Work”.

For example, assume a new employee starts on January 30 (Monday) and works a regular Monday - Friday shift without interruption.

- First of month following date of hire is February 1. Health coverage starts February 1, and Health contributions must be paid for the month of February.
- Health contributions must be paid for the month of March.
- Member’s 30th day of work is March 10 (Friday). This satisfies the coverage qualification period requirement of 30 days worked within 90 days.
- First day following end of coverage qualification period is March 11. Life Insurance coverage begins on that date, but no additional contribution is due for March.
- First of month following end of coverage qualification period is April 1. Although this is a Saturday, the member is “Actively at Work”, having worked their last scheduled day (March 31).

Coverage for AD&D, WI, and Dental therefore starts on April 1. Since Life and Health are already in effect, the member now has full coverage. Full contributions are due for the month of April.

Occasionally an employee who was previously a casual worker becomes a regular employee and qualifies for full benefit coverage. Coverage for all benefits (with the exception of Health) will then start on the first of the month following completion of the Coverage Qualification Period. Health will start on the first of the month following the date that the employee became available for full time employment.

“Transferred-In” Employees

This applies to employees who, within the last 18 months, were covered under the Southern Interior Health & Welfare Plan, or one of the designated Plans with which Southern Interior has portability, either as an active employee or under the disability provisions of the Plan. Note that this definition applies equally to laid-off employees of other companies, or to your own laid-off employees whose lay-off coverage has expired.

All benefits start on the first day of work.

For example, assume a transferred-in employee starts on March 6 (Monday), and works a regular Monday - Friday shift without interruption.

- First day actively at work is March 6. All benefits start on that day, and March contributions are due, since employee’s coverage date was between March 1 and 15, inclusive.

For example, assume another transferred-in employee started on March 20 (also Monday), and also works a regular Monday - Friday shift. All benefits start on March 20, the only difference from the above example is that March contributions are not due, since their coverage date was between March 16 and 31, inclusive.

Termination of Coverage

Assume an employee with three years seniority is laid off on August 15th, and is not recalled. Their lay-off coverage is 6 months.

- Coverage for AD&D and WI terminates February 15th.
- Coverage for Dental and Health terminates February 28th.
- Coverage for Life terminates March 15th (see section IV)
- Contributions are due for February, but not March. Even though some benefits terminate between February 1 and 15, significant benefits remain until the end of the month. However, no charge is made for the Life Insurance extension.

Assume another employee quits on September 22nd. Termination of employment is immediate, and no lay-off extension applies.

- Coverage for AD&D and WI terminates September 22.
- Coverage for Dental and Health terminates September 30.
- Coverage for Life terminates October 22 (see Section IV).
- Contributions are due for September, but not for October.

Leave of Absence

Full coverage remains in effect, and full contributions must be paid, for employees on Leave of Absence due to

- Disability while in receipt of Weekly Indemnity or WCB Wage Loss benefits (but see section on Disabled Employees).
- Suspension
- Parental or maternity leave
- Apprenticeship under a provincial apprenticeship program
- Bereavement
- Jury duty
- Union business
- Campaigning as a candidate for federal, provincial, or municipal elective public office
- Part-time, intermittent service in the capacity of an elected or appointed municipal officer
- Domestic violence leave

While on leave of absence for compassionate reasons, or for educational or training purposes (other than a provincial apprenticeship program), or extended vacation (CEV Leave), all benefits except Weekly Indemnity continue, as follows:

- Life and AD&D premiums paid by employer
- Dental and Extended Health premiums paid by employee
- It is the employer's responsibility to collect and remit the employee's portion to the Plan.

Disabled Employees

The possibilities for members with lengthy disabilities are:

1) member is injured off the job or suffers non-occupational illness:

Period of disability	**Employee's Benefits**	**Employer's Contribution**
Weeks 1 – 26	all	normal rate
Weeks 27 – recovery or age 60 while on LTD	Life Waiver (SIHWP) Dental, Health, (LTD Plan)	nothing
Age 60 - age 65	Life Waiver (SIHWP)	nothing

2) member is injured on the job:

Period of disability	**Employee's Benefits**	**Employer's Contribution**
Weeks 1 – 52	all	normal rate
Weeks 53 - PPD	all	nothing
PPD – recovery or age 60 while on LTD	Life Waiver (SIHWP) Dental, Health, (LTD Plan)	nothing
Age 60 - age 65	Life Waiver (SIHWP)	nothing

There is an important distinction between

- the employee's entitlement to benefits, which continues while the member is on "short-term" benefits, whether from the Plan or from WCB; and
- the employer's requirement to pay contributions, which ends after 52 weeks of weekly indemnity benefits have been paid. Due to attempted return to work or periods when no benefit is payable, this sometimes takes longer than 52 weeks elapsed time. The "cap" of 52 weeks for employees with occupational disabilities was established by the Trustees on August 22, 2002, effective October 1, 2002.

Note that for non-occupational disabilities, the member will go on LTD after 26 weeks of WI. The employer's requirement to pay contributions ends at that time. BUT, for occupational disabilities, the employer's obligation to pay contributions continues up to 52 weeks of WCB Wage Loss.

When completing the remittance form please complete the remittance month, your Company's NAME, DIVISION and SUBDIVISION NUMBER. When completing the remainder of the form, you may wish to refer to the notes and examples at the end of this section, headed "Coverage of Employees and Required Contributions".

Completing the Employer Remittance Worksheet

Use the SIHWP Remittance Template excel file to enter your remittance information for the month. This has been set up as a protected workbook with 4 worksheets as follows:

- YYYY Remittance Report – this worksheet is updated at least annually to reflect any rate changes
- Change Report – use this worksheet to list adds, terminations or transfers from health only to full benefits
- Covered EE Listing – if possible please provide a full listing of all employees you are remitting for – employee name and payroll id. The Plan Administrator will use this information to audit employee data monthly
- Supplemental Payroll Form – use this form if you had an employee on WI who returned to work within 3 months when there has been a statutory holiday within the time period during which the employee received WI benefits – see the section on Statutory Holidays for more information about how to use this worksheet

Calculate the Number of Covered Employees

1. Enter number of employees covered during previous month from the previous month's Billing Form (i.e. Item 5).

2. Enter number of new and returning employees who became covered for full benefits since you completed the previous month's bill. List additions on the Change Report worksheet."

NOTE: If a new employee becomes eligible immediately because he was previously covered within 18 months (see Section II(B) of this Administration Manual) while still on lay-off coverage under their previous employer, a duplicate payment may result if both you and the previous employer pay for the same month. If so, the administrator will allow the appropriate credit by means of an Administrator's Adjustment Memo. The previous employer will pay for the month if hire date is 16-31. You, as the new employer will pay if hire date is 1-15.

3. Number of employees who became eligible for Extended Health Care only - list on the Change Report worksheet, in the section "ADDITIONS - EXTENDED HEALTH CARE ONLY". When these members become eligible for all benefits you will list their names again as "ADDITIONS OR TRANSFERS - ALL BENEFITS".
4. Number of employees whose coverage terminated refers to those employees whose coverage under the Plan terminated since you completed the previous month's bill - list terminations on reverse of form.

NOTE: Review the section on termination of coverage to confirm whether remittance is owed for a terminating member.

Calculate the Amount of Contribution

Enter the number of covered employees in each of the categories lists. Amounts on the worksheet will calculate automatically based on the rates shown. Each type of coverage has a different rate, as determined by the Trustees from time to time (see "RATES" section which follows).

a) contributions due for employees who are covered for all benefits under the plan, times the monthly rate.

b) contributions due for employees who are covered for Extended Health Care only under the Plan, times the monthly rate.

c) contributions due for employees who are on leave of absence for Compassionate, Educational or Training purposes (CEV Leave), times the monthly rate. List these employees on Change Report worksheet.

d) contributions for Designated Part Time employees

e) contributions due for extended coverage for surviving spouse (note this must be approved - list covered member on the Change Report worksheet.

If you have adjustments for prior months for an employee change that was not reported or reported incorrectly, note this in Section 9 – Adjustments and enter the amount of the adjustment. Provide a detailed explanation for the adjustments.

From time to time to the Plan Administrator may ask you to make adjustments based on changes that have been processed. In this case the Plan Administrator will issue a request in writing for the adjustment and this should be processed on your next monthly remittance following the date you receive it.

You can also use this section to report employees in special situations, for example is an employee whose WI or WCB Wage Loss has expired but whose LTD claim is still being adjudicated. Their Dental and Health coverage is continued at no cost to the employer (i.e. rate = $0) for up to three months pending LTD adjudication. An employee in this section would be reported as "1 times $0 = $0".

Total Payment for the Month

The total payment amount is calculated automatically based on the information you have entered.

Payment can be made by cheque or by EFT. You can request further details and payment instructions by emailing sihwp@aga.ca.

Submit Your Payment and Forms

Your form in either excel or PDF form must be submitted to the Plan Administrator (or Head Office according to your Company's procedures - see page 1) a monthly basis, along with any enrolment and change forms (however enrolment and change forms can be submitted during the month as well).

Payment and the remittance form must be received by the administrator by the end of the month for which payment is being made. Interest is charged on overdue accounts.

Remittance Rates

There are different rates for different classes of coverage. Following are notes on how the rates are set by the Trustees. Note that in each case, the "cost" is the projected cost per member per month, as estimated by the Plan's actuary based on past experience, recent trends, and the expected impact of any benefit changes.

These costs are communicated to you by the Plan Administrator each time there is a rate change, in advance of any change in rates if possible. You can request a copy of the remittance rate information by emailing siwhp@aga.ca.

a1) All benefits, full-time

The rate is the sum of the costs for each line of benefit, PLUS the cost of Plan overhead ("expenses") PLUS OR MINUS, if applicable, any Reserve Loading (the projected amount to run-off an accumulated surplus or amortize an accumulated deficit).

a2) All benefits, designated part-time

Under the cost-sharing letter of understanding for designated part-time employees, the Employer pays 1/2 the full cost of benefits, expenses and Reserve Loading, as described under (a1) above.

The Employee pays the other 1/2 of benefits, but excluding

- WI, because under the letter of understanding, designated part-time employees are coverage for only 1/2 of the WI benefit, to be paid by the employer; and
- Reserve Loading, because historically the surpluses or deficits were mostly due to fluctuations in WI claims experience, and designated part-time members don't pay WI.

b) Extended Health Care only

The rate is simply the cost for Extended Health Care. Expenses and Reserve Loading are not included. The Health-only rate has long been a feature of the Plan, and was established before expenses and Reserve Loading were formally included in contribution rate setting.

c) Leave of absence

Employees on LOA are covered for all benefits except WI.

The Employer pays the cost of AD&D, Life Insurance (including funding for "Waiver") and 1/2 the cost of expenses.

The Employee on LOA pays the cost of Dental, Health, and 1/2 the cost of expenses.

There is no Reserve Loading, because historically the surpluses or deficits were mostly due to fluctuations in WI claims experience, and members on LOA are not covered for WI.

d) Employees in special approved, situations

There may be others, but two are documented:

Members on disability who take a severance package

These members, while in receipt of WI or WCB Wage Loss, remain covered for WI and Life Insurance (including "Waiver") only, so the Employer pays the cost of those benefits, plus expenses.

Dependents of deceased member

These dependents remain covered for Dental and Health only, so the Employer pays the cost of those benefits. Expenses are not included on compassionate grounds.

Remittance Template – Remittance Rpt

An excel template is provided to all employers each time there is a change to the remittance rates. Employers are requested to use this workbook to ensure that remittances are calculated correctly and all employee changes are captured.

SOUTHERN INTERIOR HEALTH & WELFARE PLAN

RATES EFFECTIVE JANUARY 1, 2026

Payment is due at the Plan Office no later than the last day of the month for which payment is being made. Interest is charged on late payments.

Enter information in the green shaded sections below

EMPLOYER NAME	**POLICY NO:** 907704
	DIV NO:
	SUBDIV NO:
	REMITTANCE MONTH:

A. CALCULATE NUMBER OF COVERED EMPLOYEES

1. Number of Employees covered during previous month (item 5 on previous billing). *Includes previously covered for EHB, now covered for all benefits. List on the Change Report*	0
2. PLUS Number of new Employees covered for All Benefits. *List on the Change Report*	0
3. PLUS Number of new Employees covered for EHB only. *Attach enrollment cards and list on the Change Report. Count only employees whose coverage is effective from the 1st to the 15th inclusive*	0
Terminations off of Ext. Health only *Count only employees whose coverage terminates from the 1st through the 15th of the month, inclusive*	0
4. MINUS Number of Employees whose coverage terminated since previous report. *List on the Change Report*	0
5. EQUALS Total number of covered employees during current month.	0

B. CALCULATE AMOUNT OF CONTRIBUTIONS

6. Contributions for current month	**Number**	**x**	**ate (less GS**	**=**	**Payment**
a. Employees covered for all benefits	0		$ 338.53		$ -
b. Employees covered for EHB only	0		$ 112.92		$ -
c. Employees on leave of absence for compassionate, educational or training. List on the change report worksheet	0		$ 278.44		$ -
d. Designated Part Time employees	0		$ 308.49		$ -
e. Extended coverage Surviving Spouse	0		$ 218.45		$ -
f. Bridging to Retirement	0		$ 231.16		$ -
7. Total for Employees a to f	0				$ -
8. GST (Reg #R129016945)			$1.47		$ -

9 Adjustments for previous month (CR or DR). Please explain.

Total adjustments from above	$ -

C. TOTAL PAYMENT FOR THE MONTH $ 0.00

D. SUBMIT YOUR PAYMENT AND FORMS TO THE SIHVP PLAN OFFICE

9. Email this remittance form to sihvp@aga.ca by the last day of the contribution month

10. Send a copy of this form with any original Termination Cards, Enrolment Cards or Employee Change forms to:

Southern Interior Health & Welfare Plan Office
c/o AGA Benefit Solutions
3018-675 Cochrane Drive
Markham, ON L3R 0B8
Email: sihvp@aga.ca

11. If paying by cheque mail cheque to the SIHVP c/o AGA Benefit Solutions at the address above
If paying by EFT, email payment confirmation to sihvp@aga.ca

NOTE: If payment is made by head office please send a copy of this form to your head office for consolidation with the billing forms from other divisions of the Company with enough time for payment to be made to the Plan by end of the month

Remittance Template – Change Report

SOUTHERN INTERIOR HEALTH & WELFARE PLAN 907704

Changes for:

ADDITIONS - EXTENDED HEALTH BENEFITS ONLY					
Name	EE #	Date of HIRE	Effective Date of Coverage	Enrollment Card Enclosed?	comments

ADDITIONS OR TRANSFERS - ALL BENEFITS					
Name	EE #	Date of HIRE / * RECALL	Date 30 in 90 Reached	Effective Date of FULL Coverage	On EHB only Previous Mo?

TERMINATIONS (Includes 3/6 mo. Laid-off Coverage)					
Name	EE #	Reason for Termination	Last Day Worked	Termination Date	Comments

EMPLOYEES ON LEAVE OF ABSENSE FOR COMPASSIONATE, EDUCATIONAL, TRAINING, OR EXT'D VACATION					
Name	EE #	Date Leave Granted	Expected Duration	Reason	

Note:

If the employee's coverage is being terminated and the employee is still disabled and not able to work (occupational or non-occupational) please request and "Application for Waiver of Premium Disability Benefit".

Remittance Template-Supplemental Payroll Form

SOUTHERN INTERIOR HEALTH & WELFARE PLAN

SUPPLEMENTAL PAYROLL FORM

STATUTORY HOLIDAY REPORTING FORM

Calculation for payment upon Return to Work from illness or injury covered by Weekly Indemnity under the Southern Interior Health and Welfare Plan for employees who have returned to work within 90 days from their date last worked

Please complete all highlighted fields below and send a pdf copy of this form to SIHWP by email at sihwp@aga.ca. If you are paying by cheque please include a copy with your cheque payment

EMPLOYER NAME	**0**	**Division/Subdivision**	-
EMPLOYEE NAME		**Date**	**July 15, 2026**

Under the Qualifying Conditions of Artcile XIII - Statutory Holidays and Floating Holidays you qualify for the following Statutory Holidays:

Statutory Holiday Date Enter the stat holidays that occurred during the time the employee was covered for Weekly Indemnity benefits	**Hours** EE's reg worked hrs/day	**Rate** EE's Hourly Pay Rate	**Amount**	
			0.00	
			0.00	
			0.00	
			0.00	
			0.00	
TOTAL AMOUNT PAID BY THE COMPANY			**0.00**	(a)
Under the Weekly Indemnity provisions of the Southern Interior Health & Welfare Plan you have been paid the followng for the above Statutory Holiday(s) (Weekly Indemnity Daily Rate x # of Days)	**WI Daily Rate**	**# of Days**		
	118.43	0	**0.00**	(b)
As a result you are entitled to the following balance from us ((a) - (b)):			$ -	(c)

With the remainder (the amount paid by the Plan) to be reimbursed by the Company to the Southern Interior Health and Welfare Plan as follows:

TOTAL REIMBURSEMENT	**$**	**0.00**
(equal to the amount (b) above)		

VII. CLAIMS

Weekly Indemnity Benefit

When a claim is to be made to this benefit the form headed “Claim for Employee Weekly Indemnity Benefits” should be fully completed by the Employee, Employer and Attending Physician. To eliminate delays in the payment of the benefit, it is essential that this form be correctly and fully completed.

Members must also be informed of the timelines to submit a claim.

The employee must first complete the “Employee’s Statement”. The employer must then complete the “Employer’s Statement”, and the employee’s doctor must complete the “Attending Physician’s Statement”. Typically, the employee will return the completed claim form to you, however they can submit their portion of the claim directly to Pacific Blue Cross. If the employee and physician statement are returned to the employer they should be submitted to Pacific Blue Cross.

NOTE: Question 14 of the “Employees Statement” (Summary of educational and work experience), and the description of job duties requested in the “Employer’s Statement” are not normally required if the disability is expected to be of brief duration. They are especially important where the disability is severe and likely to be prolonged, particularly if in the judgment of the attending physician the employee is a suitable candidate for a vocational rehabilitation program (Question 23). Since the claim form may not go through the employer’s office after the “Attending Physician’s Statement” has been completed (see above), it may be necessary to consult by telephone when deciding how much information to supply.

Weekly Indemnity benefit cheques are issued every two weeks once a claim has been established. These cheques are mailed to the Employer for delivery to the disabled member or paid electronically if the member has completed the electronic deposit form.

From time to time Pacific Blue Cross will require completion of an “Additional Weekly Indemnity Benefits’ form which also includes a “Supplementary Report of Attending Physician” before further payments will be made.

NOTE: On the day the employee returns to work a “Return to Work Notice” should be completed by you and emailed to the Plan Administrator.

Please note Weekly Indemnity benefits are not paid to employees who are on leave of absence for Compassionate, Educational or Training purposes or Extended Vacation (CEV Leave). If disabled on the date the leave of absence expires, employees may receive benefits if they have returned to B.C. or if hospitalized in B.C. in a hospital recognized by the B.C. Medical Plan.

At any time, you as employer are entitled to contact Pacific Blue Cross for information on the status of the claim, specifically, the expected return to work date.

Workers Compensation Board Reimbursement Agreement

1. If an employee has applied for and is refused a Workers' Compensation Board benefit or if the Workers' Compensation Board is delayed, the employee may complete a Reimbursement Agreement and present a claim for Weekly Indemnity benefits.

   Note: A reimbursement agreement is not required if the employee is making a claim and is in receipt of a permanent partial disability pension from the W.C.B. and is not appealing the decision of the W.C.B.

2. The Reimbursement Agreement is reviewed and signed by the employer and forwarded along with the Wage Indemnity claim form.

3. When the Wage Indemnity claim is approved and benefits paid, a copy of the Workers' Compensation Board Reimbursement Agreement is provided to Workers' Compensation Board so that any subsequent approval and payment for Wage Loss by the Workers' Compensation Board will be processed through Pacific Blue Cross.

4. When Pacific Blue Cross receives a Wage Loss benefit cheque from Workers' Compensation Board following a successful appeal, that cheque is payable to the employee.

   The back of the Workers' Compensation Board cheque is endorsed for deposit to the Southern Interior Health & Welfare Plan, and the Workers' Compensation Board cheque is accompanied by a Trust Fund cheque paying the employee the difference between the amount that is owed to the Health & Welfare Plan and the benefit paid by Workers' Compensation Board.

5. The employer will receive:

- the Workers' Compensation Board Wage Loss cheque.
- the Trust Fund cheque
- a statement outlining the calculation and
- a letter asking that the Workers' Compensation Board cheque is signed by the employee and returned to PBC, and that when the Workers' Compensation Board cheque is endorsed, the Trust fund cheque be given to the employee.

Canada Penson Plan (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 their 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 their physician the disability is severe and likely to be prolonged, an early application for CPP Disability Benefits may be helpful to the employee.

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 office of Health & Welfare Canada's Income Security Programs. 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.

Statutory Holidays

On May 29, 1998, the IFLRA wrote to all Participating Employers announcing a method agreed to by the parties to avoid double payment for statutory holidays for employees returning from weekly indemnity (WI) within the 90 day qualification period (Article XII, Section 2(f)).

1) The WI benefit is paid for all days for which a claimant qualifies including any statutory holidays falling within the period of claim.
2) When an employee returns to work within 90 days of last day worked, the employer is required to pay the employee for any statutory holidays falling within the 90 day (or less) period.
3) The employer deducts the amount paid for each statutory holiday by the WI plan from the amount paid to the employee for the same day. The employer then reimburses the WI plan with the amount deducted, by including it with their next remittance to the Southern Interior Health & Welfare Plan.

The IFLRA prepared, and distributed to Participating Employers, a "Supplemental Payroll Form – Statutory Holidays", for this purpose.
Rate for 1998 to 2009 - At the time this agreement was reached, the amount for a statutory holiday paid for under the WI plan (the WI daily rate) was $449 per week, divided by 7, or $64.14.

NOTE that the new daily rate is only in effect for new disability claims on or after January 1 of each year.

Rates for 2026 – The weekly WI benefit increased to $829 per week for new claims beginning January 1, 2026 or later therefore the WI daily rate changed to $829 / 7 = $118.43.

For employees who work a Compressed Work Schedule, disability benefits are paid on different basis so you may need to confirm with PBC whether or not the employee was paid WI benefits for the statutory holiday. If the employee was not paid WI benefits then the employer may responsible for reimbursing the employee the statutory holiday pay. If WI benefits were paid, PBC can confirm the amount paid for the day and a custom calculation would need to be done.

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.

Weekly Indemnity Claim Form



SOUTHERN INTERIOR HEALTH & WELFARE PLAN

Weekly Indemnity Benefits Claim

To avoid any delay in the processing of your claim, please be sure ALL questions are answered.

If printing this form from the internet, keep it clipped or stapled to ensure all 9 pages are submitted to Pacific Blue Cross.

NOTICE OF CLAIM must be given not later than 30 days following the first day of illness or accident and proof submitted within these 30 days.

NOTE:
A reimbursement agreement on a separate form provided by the plan must be completed in the case of claims where a full and proper WCB claim has been filed at least four weeks earlier and for which no decision has been reached or the claim disallowed.

Mailing Address:
Southern Interior Health & Welfare Plan
c/o Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

Telephone:
1 888 275-4672 *(toll free)*
604 419-8080

Fax:
604 419-8099

Administered under contract number 907704 by:
Pacific Blue Cross

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

1. PERSONAL INFORMATION

Name (first, middle, last)		☐ Mr. ☐ Ms. ☐ Miss. ☐ Mrs.
Date of birth (mm-dd-yyyy)	Social Insurance Number	Local union number
Street address		
City	Province	Postal code
Mailing address (if different from above)		Phone number

Do you want your cheque sent to the mailing address? ☐ Yes ☐ No

2. DISABILITY INFORMATION

When did your sickness begin or accident happen? Date (mm-dd-yyyy)

Date last worked Date (mm-dd-yyyy)

On what date did disability prevent you from working? Date (mm-dd-yyyy)

Have you ever had the same or similar illness? ☐ Yes ☐ No If yes, state when and describe Date (mm-dd-yyyy)

Is disability due to an injury? ☐ Yes ☐ No If yes, what kind of injury: ☐ MVA ☐ Work ☐ At home ☐ Other

Describe how and when the injury occurred Time _____ ☐ AM ☐ PM Date (mm-dd-yyyy)

Is there any third party legal action involved? ☐ Yes ☐ No If yes, please provide lawyers' name and address:

Legal representative's name: _____

Legal representative's address: _____

Note: Reimbursement Agreement and Direction on page 5 to be completed for all claims resulting from an accident where a third party is involved.

If injury at work, has a WCB claim been filed? ☐ Yes ☐ No WCB claim number Date claim filed (mm-dd-yyyy)

Has an appeal been filed? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Does this disability relate to a previous WCB claim? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Are you receiving WCB disability benefits? ☐ Yes ☐ No If yes, provide the frequency and amount of benefits.

Frequency of benefits: _____ Amount of benefits: $ _____

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

Have you been hospitalized for this sickness/injury? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: | Admission date (mm-dd-yyyy) | Discharge date (mm-dd-yyyy)

Did you visit the emergency room? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: | Admission date (mm-dd-yyyy) | Discharge date (mm-dd-yyyy)

Please provide the following information about the family doctor who has your **medical records**.

Last name of doctor	First name of doctor	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits
City	Province	Type of treatment received	
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)	

Please provide the following information about **any other specialist or health care practitioner** you have seen or are scheduled to see for this condition.

Last name of doctor	First name of doctor	Specialty	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)		

Last name of doctor	First name of doctor	Specialty	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)		

Have you been referred to a specialist? ☐ Yes ☐ No If yes, provide the name and date.

Name of specialist: | Date (mm-yy-dddd)

Have you returned to work? ☐ Yes ☐ No If yes, when? If no, when do you expect to return? | Date (mm-yy-dddd)

3. SUMMARY OF EDUCATION, TRAINING AND EXPERIENCE

School grade reached? Work experience?

Other training, upgrading, on-the-job training or special interests:

Does your job require a professional certificate, licence or other qualifications? ☐ Yes ☐ No
If yes, please describe:

Do you have a valid driver's licence? ☐ Yes ☐ No | Class | Restrictions

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

I certify that the answers given are complete, current and accurate to the best of my knowledge and belief.

I agree to refund any monies which may be due to the Southern Interior Health & Welfare Plan c/o Pacific Blue Cross as a result of payment of disability benefits from any source in accordance with the provisions of the Southern Interior Health & Welfare Plan Text.

I authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, the Workers' Compensation Board of BC/Review Board/Medical Review Panel to release to Pacific Blue Cross, the Trustees of the Southern Interior Health & Welfare Plan, Evergreen Rehabilitation Management Society and the Trustees of the IWA-Forest Industry LTD Plan, any medical or benefit payment information, or any other information or records that may be requested by Pacific Blue Cross to establish or review the validity of this claim for Weekly Indemnity benefits for the period commencing (mm-dd-yyyy): _____

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information regarding the duties and requirements of my job to establish or review the validity of this claim for Weekly Indemnity benefits.

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information required to develop a Recovery Plan and/or Return to Work Program.

I authorize the Southern Interior Health & Welfare Plan and its Agents to release to my employer information regarding my expected return to work.

I authorize the use of my Social Insurance Number for the purpose of tax reporting and for the identification and administration of my Group Benefits.

I understand the Weekly Indemnity benefit will be reduced by Income Tax withholding as required by CRA.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge I must notify Pacific Blue Cross, as the agent of the Southern Interior Health & Welfare Plan, immediately should:

a) My medical condition improve so that I would be able to work, even though I have not yet returned to work,
b) I go to work whether as an employee or as a self employed person,
c) I apply for benefits under any Workers' Compensation law or plan,
d) I apply for benefits under Canada/Quebec Pension Plan,
e) I am discharged from hospital if I am hospitalized,
f) I return to work or receive any benefits/income related to my disability,
g) I apply for benefits from the IWA-Forest Industry Pension Plan.

Employee's signature X		Date signed (mm-dd-yyyy)
Employee's name (please print)	Policy number 907704	Certificate number/member ID

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5. REIMBURSEMENT AGREEMENT AND DIRECTION

Re: Group Contract No. 907704 between:
THE TRUSTEES OF THE SOUTHERN INTERIOR HEALTH & WELFARE PLAN and

Member name

Address | Member ID number

PART 1 — DEFINITIONS

PLAN refers to the Southern Interior Health & Welfare Plan.
PACIFIC BLUE CROSS, as agent for the Trustees of the PLAN.
YOU, YOUR and the MEMBER refer to the member with whom this agreement is made.
ACCIDENT refers to the incident giving rise to your claim for benefits from the PLAN.
THIRD PARTY refers to any other person from whom you may be able to recover damages as a result of your accident.

PART 2 — THE CONTRACTUAL ARRANGEMENTS

You may have a right to recover damages from a THIRD PARTY as a result of your illness, injury or income loss which arose from an ACCIDENT which occurred on (mm-dd-yyyy): _____

Under the terms of the PLAN, you are entitled to claim Weekly Indemnity (WI) benefits in respect of some or all of the period you have been absent from work commencing (mm-dd-yyyy): _____

You agree to take all neccessary steps to recover from the THIRD PARTY the benefits which the PLAN has paid, or will in the future, pay to you. If you fail to take such steps you agree that PACIFIC BLUE CROSS may do so on your behalf, and you hereby assign to PACIFIC BLUE CROSS the right to do so in accordance with the terms of the PLAN.

If you are able to recover such benefits from a THIRD PARTY, you will repay the PLAN, c/o PACIFIC BLUE CROSS, in accordance with the terms of the PLAN. The following is a summary of the reimbursement formula:

Reimbursement Amount = (WI Benefits Paid + Gross Wage Loss Recovery) – (Lost Wages + Pro-rata Share for Legal Expenses);

- WI Benefits Paid is the amount of benefits actually paid to you up to your Settlement Date.
- Gross Wage Loss Recovery is the lesser of your Gross Settlement and your Lost Wages.
- Lost Wages is calculated by multiplying your regular job rate times 40 hours per week, times the number of weeks you receive WI benefits prior to your Settlement Date. Lost Wages will reflect scheduled increases in your hourly job rate during the disability period.
- The Pro-rata Share of Legal Expenses is your Legal Expenses multiplied by your Gross Wage Loss Recovery divided by your Gross Settlement (to a maximum of 20% of your Gross Wage Loss Recovery).
- For greater certainty, Legal Expenses includes legal fees, disbursements and all applicable taxes, including any GST or SST paid to your lawyer. In no event shall the amount allowed for the Pro-rata Share of Legal Expenses exceed 20% of your Gross Wage Loss Recovery. Disbursements and taxes paid on the legal fees are *included* in the 20% of Gross Wage Loss Recovery.

If you abandon or settle any claim you have against the THIRD PARTY without the written consent of PACIFIC BLUE CROSS, your Reimbursement Amount will equal the full amount of benefits received by you. In addition, if you wish PACIFIC BLUE CROSS to consider accepting less than full reimbursement of benefits paid, you will instruct any legal representative acting for you to give PACIFIC BLUE CROSS a full report of the details of any proposed settlement between you and the THIRD PARTY, for PACIFIC BLUE CROSS approval before any settlement is reached.

You hereby authorize and direct anyone (including ICBC) with knowledge of your ACCIDENT or any settlement relating to it to release to PACIFIC BLUE CROSS the details of any settlement you reach.

You agree to provide full details of any settlement to PACIFIC BLUE CROSS, and pay the Reimbursement Amount calculated above to PACIFIC BLUE CROSS as soon as you receive your settlement payment.

You hereby assign to PACIFIC BLUE CROSS all of your interest in any amount that is owing to you in respect of the ACCIDENT, up to the amount of the Reimbursement Amount calculated above. In particular, you irrevocably authorize, instruct and direct any legal representative who acts for you to pay PACIFIC BLUE CROSS the Reimbursement Amount out of any settlement payments received on your behalf.

The foregoing is a summary of the relevant terms of the PLAN. In the event of an inconsistency between this form and the PLAN, the PLAN prevails. You may obtain a copy of the relevant terms of the PLAN at any time at no charge.

PACIFIC BLUE CROSS, as agent for the Trustees of the Southern Interior Health & Welfare Plan (OFFICE USE ONLY) | Date (mm-dd-yyyy)

Member **X** | Witness **X**

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYER'S STATEMENT

1. EMPLOYER INFORMATION

Name			Division
Street address			
City		Province	Postal code
Contact name	Title	Phone number	Fax number

2. EMPLOYEE INFORMATION

Name (first, middle, last)	Social Insurance Number	Date of birth (mm-dd-yyyy)
Seniority date (mm-dd-yyyy)	Date last worked (mm-dd-yyyy)	

Job Classification: attach job description and physical requirements

At the beginning of absence, the employee was:

☐ A regular full-time employee — For those employees working alternative shifts, please check days off: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

☐ Is this employee on an alternate schedule? ☐ Yes ☐ No — If yes, provide details:

☐ A regular laid-off employee — Date lay-off commenced (mm-dd-yyyy)

When laid off, this employee was entitled to _____ months continuation of lay-off coverage.

☐ A designated part-time employee — Provide details

☐ On leave of absence — From date (mm-dd-yyyy) To date (mm-dd-yyyy) Reason for leave of absence

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

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

Is this claim one which might come under the Workers' Compensation act? ☐ Yes ☐ No
If yes, please submit copies of relevant WCB letters or correspondence.

Has employee returned to work? ☐ Yes ☐ No If yes, provide date of return — Date (mm-dd-yyyy)

Has employee claimed weekly indemnity benefits during the previous 4 weeks? ☐ Yes ☐ No

Have you any reason to question the validity of this claim? ☐ Yes ☐ No If yes, state reason:

_____

Who is the company contact for return-to-work issues? — Contact name — Phone number

Do you have a transitional work program or disability management program? ☐ Yes ☐ No If yes, describe:

_____

Is modified work available? ☐ Yes ☐ No If yes, describe:

_____

3. SIGNATURE

I certify that the above statements are correct.

Signed for employer by **X**	Date signed (mm-dd-yyyy)

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is claiming disability benefits from Southern Interior Health & Welfare Plan. As an initial step in the entitlement process, we ask that you complete this form, providing sufficient clinical information to enable us to make an informed decision. Incomplete information may delay the payment of your patient's claim.

Instructions:

1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

1. PATIENT AUTHORIZATION

Name	Policy number	Certificate number/Member ID
	907704	

I hereby authorize the release, to Pacific Blue Cross and Evergreen Rehabilitation Management Society, of any medical information, including copies of consultation and/or office notes and test/investigative reports, with respect to this claim for the period commencing (mm-dd-yyyy): _____

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

2. ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS

Primary Diagnosis: _____

Secondary diagnoses or complications:

_____

Please describe any functional impairment or restrictions for your patient's ability to work:

_____

_____

Are these ☐ temporary or ☐ permanent? If temporary, expected duration: From (mm-dd-yyyy) To (mm-dd-yyyy)

CLINICAL INFORMATION

What date did symptoms first appear/accident happen? Date (mm-dd-yyyy)

How long has your patient had this condition? _____

Condition is due to ☐ Illness ☐ Injury ☐ Work-related ☐ MVA ☐ Other (specify below):

_____

What are your patient's current symptoms? _____

What are your clinical findings? _____

What are the dates of the first and latest visits for this condition? Date of first visit (mm-dd-yyyy) Date of latest visit (mm-dd-yyyy)

Dates of Visits (✔) exclusive of above procedures

PLACE	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																																	

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is: ☐ Ambulatory ☐ Bed confined ☐ Home confined
☐ Ambulatory with assistive devices ☐ Hospital confined

What is your patient's current height/weight/dominant hand? Current height ____ Current weight ____ Dominant hand ☐ Left ☐ Right

If patient is hypertensive, provide the last 3 blood pressure readings:

Reading: ____ Date (mm-dd-yyyy) | Reading: ____ Date (mm-dd-yyyy) | Reading: ____ Date (mm-dd-yyyy)

If psychiatric disorder, provide current GAF Score: _____

If cardiac disorder, provide American Heart Association Functional Classification: ☐ Class I (No limitation)
☐ Class II (Slight limitation) ☐ Class III (Marked limitation) ☐ Class IV (Complete limitation)

DIAGNOSTIC INVESTIGATIONS

Please enclose copies of current consultation and diagnostic investigative reports (X-rays, scans, laboratory data, etc.)

TREATMENT

Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN OR TO BE SEEN
		(mm-dd-yyyy)
		(mm-dd-yyyy)

Current medications:

NAME	DOSAGE	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Other forms of treatment or therapies:

TYPE	EXPECTED DURATION	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Hospitalizations:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

Emergency Room treatment:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Treatment Response ☐ Recovered ☐ Improved ☐ No Change ☐ Retrogressed Comments:

Is your patient following the recommended treatment program? ☐ Yes ☐ No If no, please elaborate:

Details of any **proposed** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

LICENCE RESTRICTION

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition? ☐ Yes ☐ No

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification? Date (mm-dd-yyyy)

Would your patient be a suitable candidate for:

Vocational Rehab Program? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Modified work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Work hardening? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Graduated return to work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

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

If still unable to work, give approximate date patient should be able to return to work. Date (mm-dd-yyyy) or Estimated number of weeks before possible return to work

REMARKS

Please include any additional comments/information that you believe may help in the assessment of this claim:

3. SIGNATURE

Name of attending physician (please print)	Specialty	Phone number
Address (number, street, city, province, postal code)		Fax number
Signature X		Date signed (mm-dd-yyyy)

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Return to Work Notice

Trustees of the Southern Interior Health & Welfare Plan

Return to Work Notice

Return completed form to:

Southern Interior Health and Welfare Plan
c/o Pacific Blue Cross
PO Box 7000
Vancouver BC V6B 4E1
Phone: 1-888-275-4672 | 604-419-8080
Fax: 604-419-8099

Instructions: For any employee who has been receiving Wage Indemnity Benefits, complete this form the day he returns to work.

POLICY#: 907704 MEMBER ID: _____

EMPLOYEE NAME: _____

DATE RETURNED TO WORK: _____
Month Day Year

If employee was able to return to work at an earlier date but did not return because of a lack of work, give full details.

.....

.....

.....

.....

EMPLOYER: _____

BY: _____

DATE: _____
Month Day Year

Life Waiver of Premium

(Continuation of Group Life Insurance while disabled)

If

- upon expiration of Weekly Indemnity Benefits (26 weeks) or
- upon expiration of WCB Wage Loss benefits at the time a total and permanent disability pension is granted by the Workers' Compensation Board, or
- after 52 weeks of WCB Wage Loss benefits have been paid

the employee remains totally disabled, contributions are no longer required from the company. It is important that you identify your reasons for terminating premiums.

The member could then be entitled to Continuation of Group Life Insurance to age 65 without payment of premiums, so long as he remains totally disabled. The Plan Administrator will arrange this, contacting the member for information if necessary.

LTD claimants remain covered for Life Waiver of Premium automatically. Retiring LTD claimants between the ages of 60 and 65 may be covered. Totally and permanently disabled members whose date of disability is prior to December 11, 1983 may remain covered for life. For other members, the life waiver of premium coverage ceases at age 65.

Life and Accidental Death & Dismemberment Claims

Preliminary Notification of Death

You can use the Preliminary Notification of Death form to notify the plan administrator as soon as you are notified of the death of an employee, however you do not need to complete this form – an email confirming the employee name and as much information as you have is enough to start the claim.

The normal documentation requirements are as follows:

ALL DEATH CLAIMS

- Death Certificate or Funeral Parlour Certificate. A photocopy is sufficient.
- Completed Claimant Statement
- Completed Employer Statement – this is completed by the Plan Administrator however they may request some information from the employer.
- Copies of all beneficiary and enrolment forms – these are maintained by the Plan Administrator.

ACCIDENTAL DEATH/SUICIDE

Additional information is required for death claims resulting from accidental death or suicide.

- Newspaper clipping and/or police report (where available).
- Coroner's Report - The Plan office provides a form letter to assist the family in obtaining this document.
- Autopsy report

Where additional benefits may be payable under the Accidental Death provisions like the loss of limb or loss of use, additional forms must be completed.

DEATH CLAIMS PAYABLE TO ESTATE

If the Estate has been named the beneficiary, 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
- Letters of Administration

DEATH CLAIMS PAYABLE TO MINOR

The following information is required when the named beneficiary has not attained age 18:

- Name of guardian, and their relationship to the child.
- Address at which the child resides, and with whom.
- Copy of child's birth or baptismal certificate.

If the beneficiary is under 18 years of age the benefit can be handled in the following ways:

- If a Trustee is named on the beneficiary designation, the proceeds can be paid into a Trust account established by the Trustee.
- The money can be held in Trust by the insurance carrier until the beneficiary reaches their 18th birthday, during which time interest accrues.
- The money can be paid to a guardian or executor of the estate to be used for the beneficiary, in which case a notarized copy of Letters of Guardianship will be required.

Preliminary Notification of Death Form



Southern Interior Health & Welfare Plan

c/o AGA Benefit Solutions
301E-675 Cochrane Drive, Markham, ON L3R 0B8
Phone: 1-800-218-7018 FAX 905-477-2249 Email sihwp@aga.ca

Please mail, fax or email this form as soon as you receive notice of an employee death to the Southern Interior Health & Welfare Plan.

PRELIMINARY NOTIFICATION OF DEATH

Employer Name	Click or tap here to enter text.
Employer Division Number	Click or tap here to enter text.
Name of Deceased	Click or tap here to enter text.
Member's Address	Click or tap here to enter text.
Job Title	Click or tap here to enter text.
Date Last Worked	Click or tap to enter a date.
Date of Death	Click or tap to enter a date.
Cause of Death	Click or tap here to enter text.
Designated Beneficiary(ies) & relationship (*include any contact info you have)*	Click or tap here to enter text.

When a claim is to be made for this benefit the following forms are required. These are available from the Plan Administrator, and when complete should be returned to the Plan Administrator.

1) Statement of Employer/Policyholder, Accidental Death or Dismemberment.
2) a) Statement of Beneficiary for Accidental Death, or
   b) Statement of Claimant for Eye Loss, or
   c) Statement of Claimant for Limb Loss
3) a) Statement of Attending Physician (Accidental Death claim)
   b) Statement of Attending Physician (eye loss)
   c) Statement of Attending Physician (limb loss)
   d) Statement of Attending Physician, Loss of Use
4) Statement of Eye Witness

For further information on the Plan please refer to the Plan Text or contact your Head Office or the Administrator. Remember, the Accidental Death benefit is not paid in cases of suicide.

FORM - ACCIDENTAL DEATH REQUEST FOR CORONER'S REPORT

Chief Coroner for British Columbia
4595 Canada Way,
Burnaby, B.C.
V5G 4L9

Attention: Mr. R.W. Galbraith

SOUTHERN INTERIOR HEALTH & WELFARE PLAN ADMINISTRATION MANUAL

Dear Sir,

! _____ (name), _____ (relationship) of _____ (deceased name) who died on _____ (date of death) at _____ (location) request a copy of the autopsy report and the coroner's findings of facts and any other examinations or analysis carried be sent to me to be used in the adjudication of an insurance claim with _____

Yours truly,
Signature
(Address)

E. EXTENDED HEALTH CARE

Employees can submit health claims to Pacific Blue Cross online through https://service.pac.bluecross.ca/member/login/. This is the fastest way to get claims reimbursement.

Employees who do not want to submit claims online can use the Pacific Blue Cross Standard Health Claim form to submit claims by mail.

Health Claim Form

PACIFIC BLUE CROSS

DO NOT WRITE IN THIS SPACE

STANDARD HEALTH CLAIM FORM

PLEASE DO NOT STAPLE

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

Use this form to submit a claim for all medical expenses and services. **Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim.** See page 2 for important information about preparing your claim.

PART 1 — MEMBER INFORMATION

Policy number | ID number | Name of plan, company name or Plan sponsor (if applicable)

First name | Last name | Employment status ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student | Daytime phone number (10 digits)

Street address | City | Province | Postal code | New address? ☐ Yes

PART 2 — OTHER INSURANCE COVERAGE

Complete this section if you or your spouse are covered under another plan. Please see the special instructions for coordination of benefits on page 2.

Other insurance coverage ☐ Pacific Blue Cross ☐ Other insurer: _____ | Coverage start date (mm-dd-yyyy)

Member's policy number | Member's ID number | Plan member ☐ Same as above ☐ Spouse | Cancellation date if applicable (mm-dd-yyyy)

Spouse's first name if spouse's plan | Spouse's last name if spouse's plan | Employment status of spouse ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student | Spouse's birthdate (mm-dd-yyyy)

PART 3 — INFORMATION ABOUT YOUR CLAIM(S)

Please provide the first name and birthdate for each eligible person with a claim. For each person, add up all receipts and provide the total amount of their expenses.

If any expenses are the result of a medical emergency outside your province, visit Member Profile to download an *Emergency Out-of-Province Claim Form*.

Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	GRAND TOTAL	$

If yes to either of the following questions, please complete an *Accident or Injury Reimbursement Agreement Form* available on Member Profile.

1. Are the expenses you're claiming: The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☐ No
   The result of a motor vehicle or other accident? ☐ Yes ☐ No
2. Are you seeking damages from a 3rd party? ☐ Auto ☐ WorkSafeBC ☐ Other: _____

PART 4 — HEALTH SPENDING ACCOUNT (HSA): Complete only if you have an HSA, see page 2 for more information

If applicable, apply any unpaid balance(s) to your HSA? ☐ Yes ☐ No

PART 5 — MEMBER CONSENT AND DECLARATION

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

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims. I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If I am making a claim under my Health Spending Account (where applicable), I acknowledge that the person(s) for whom I am making a claim are eligible and I accept full responsibility to ensure all expenses submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Income Tax Act. I understand I am responsible for payment of any taxes that arise from reimbursement of these expenses. I also agree my plan sponsor may have access to a summary of the total amounts claimed by me for the purposes of tax or administrative reporting.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

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

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

0332.001—10-60-020 03/22 CLIPS 1816

1 of 2

Medical Travel Allowance Form



Southern Interior Health & Welfare Plan
Medical Travel Allowance Referral and Claim Form

Return completed form to: **Southern Interior Health and Welfare Plan, c/o Pacific Blue Cross***
Priority Mailing Address: **PO Box 7000, VANCOUVER BC V6B 4E1**
Tel: 1 - 888 - 275 - 4672 • 604 - 419 - 2600

PART 1 - TO BE COMPLETED BY EMPLOYEE **ENCLOSE ALL ORIGINAL RECEIPTS**

Company Name & Address	Member's Name	Address
	(Last) _____	_____
Group Number / Member's Identity Number	(First) _____	Phone # _____

Patient's Name (Last) _____ (First) _____

Dependent Number _____ Date of Birth _____ D/M/Y

CLAIM FOR TRAVEL EXPENSES (Airfare, etc. - in the case of automobile, please show mileage x 30¢/km.)

From	To	Amount Claimed

CLAIM FOR ACCOMMODATION EXPENSES (You must provide receipts for all accommodation expenses)

Name of Accommodation	Location	# Days	Amount Claimed

Total Amount Claimed _____

PART 2 - REFERRAL (MEDICAL SPECIALIST) TO BE COMPLETED BY REFERRING PHYSICIAN

Patient's Name _____

Location _____

Reason for Referral _____

Referred to Medical Specialist (** see Part 3)
Dr. _____
Specialty: _____
Referral Date _____ D/M/Y
Appointment Date _____ D/M/Y

Attendant/Escort required: Yes ☐ No ☐

Reason(s) Attendant/Escort required: _____

If there is more than 2 months between the referral date and appointment date please explain why: _____

Reason for referral outside Regional Services Area: Services not available ☐ To expedite services ☐ Physician Preference ☐
Other Reason: _____

Referring Physician's signature: _____ Date: _____

PART 3 - TO BE COMPLETED BY THE MEDICAL SPECIALIST specified in Part 2**

I confirm that the above noted patient has attended the appointment as referred.

Specialist Physician signature: _____ Date: _____

I understand that expenses payable under the WCB Act or by MSP of BC, ICBC or other sources are not eligible for reimbursement and I certify that the reimbursement I am seeking is related to the medical appointment referred to above.

Member's signature: _____ Date: _____

See explanation of terms and conditions on back of form ...

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Dental Benefits

Normally, the dentist submits the claim for Dental Services directly to the Plan using the standard Canadian Dental Claim form. This is usually true even for dentists who require payment in advance from the member. However, if for any reason claim forms are required, or if assistance is required in their completion, please contact the Plan Administrator.

NOTE: Remember that pre-authorization is required for Orthodontia, and recommended for other major expenses, as outlined in the Plan booklet.

VIII. 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.

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

Calculation of Taxable Benefits

You may notice that rate of Taxable Benefit for a year is different from the cost of Group Life Insurance in the breakdown of the monthly contribution rate.

This is because the Group Life Insurance portion of the monthly contribution is 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.